



# Provider Manual

Amerigroup Kansas, Inc.



1-800-454-3730

<https://providers.amerigroup.com/ks>

May 2016

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May 2016

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Welcome to our network. We're glad to have you among our network of quality providers.

We recognize hospitals, physicians and other providers play a pivotal role in managed care. Earning your respect and gaining your loyalty are essential to successful collaboration in the delivery of quality health care.

This provider manual contains everything you need to know about us, our programs and how we work with you. This information is subject to change. **We encourage use of the manual available at [providers.amerigroup.com/KS](https://providers.amerigroup.com/KS) for the most up-to-date information.**

We want to hear from you! Participate in one of our quality improvement committees or call our Provider Services team with suggestions, comments or questions. Together, we can make a difference in the lives of our KanCare members.

# 1. INTRODUCTION

## 1.1 Who We Are

Amerigroup Kansas, Inc. (Amerigroup) is a wholly owned subsidiary of Anthem, Inc. (Anthem). As a leader in managed health care services for the public sector, health plans operated by Anthem help low-income families, children, pregnant women, people with disabilities and the elderly get the health care they need.

We help to coordinate physical and behavioral health care, as well as nursing facility and home- and community-based services (HCBS). We offer education, access to care and disease management programs. As a result, we lower costs, improve quality and encourage better health for our members.

We:

- Improve access to preventive health care services
- Ensure our members select primary care providers who serve as providers, care managers and coordinators for all basic medical services
- Help to improve health outcomes for members
- Educate our members about their benefits, responsibilities and appropriate use of care
- Utilize community-based enterprises and community outreach to help our members
- Integrate physical and behavioral health care to address the whole person
- Encourage:
  - Stable relationships between our providers and members
  - Appropriate use of specialists, urgent care centers and emergency rooms

In a world of escalating health care costs, we work to educate our members about appropriate use of our managed care system and their involvement in all aspects of their health care.

## 1.2 Quick Reference Contact Information

### Our Website

Our provider website, [providers.amerigroup.com/KS](http://providers.amerigroup.com/KS), offers a full complement of tools, including:

- Enhanced account management tools for timely updates to your contact information in our systems
- Downloadable forms
- A detailed eligibility look-up tool
- Comprehensive, downloadable member panel lists and population-centric reporting
- Easier authorization requirements look up and submissions
- Access to drug coverage information
- Special training for you and your office staff
- A list of open claim-related issues and their status

For technical support when using our provider website, call our Provider Services team. Technical support agents are available between 7 a.m. and 7 p.m. Central time.

## **Important Contact Information**

### **Our Kansas Office Address**

Amerigroup Kansas, Inc.  
9225 Indian Creek Parkway, Building 32  
Overland Park, KS 66210  
Phone: 913-749-5955  
Fax: 913-563-1680

### **Amerigroup Provider Services**

Phone: 1-800-454-3730

Live agents available:  
Monday through Friday  
8 a.m. to 5 p.m. Central time  
Fax: 1-800-964-3627

Interactive Voice Response (IVR) System available:  
24 hours a day, 7 days a week

Kansas Provider Services Direct Line: 1-877-434-7579  
Use this number for all non-claim related concerns.

Use the referral directory on our provider self-service site to find other Amerigroup network providers and substance use disorder services. For assistance in referring members to services and providers near them, call our Provider Services team.

### **Amerigroup Behavioral Health Services**

Providers call: 1-800-454-3730  
Members call: 1-800-600-4441

Fax Numbers:  
General Faxes: 1-800-964-3627  
Inpatient Faxes: 1-877-434-7578  
Outpatient Faxes: 1-800-505-1193

### **Amerigroup Member Services**

1-800-600-4441  
Live agents available Monday through Friday,  
8 a.m. to 5 p.m. Central time  
Self-service voice portal available 24/7  
Interpreter services for members are available

### **Amerigroup On Call/ Nurse HelpLine for Members**

1-866-864-2544 (Spanish 1-866-864-2545)  
Live agents available 24/7

### **Amerigroup Electronic Data Interchange Hotline**

1-800-590-5745



TTY

711

Case Managers

Call Amerigroup Provider Services. Case managers available from 8 a.m. to 5 p.m. Central time. For urgent issues at all other times, call our Provider Services team.

Claims Information

File claims online at [www.Availity.com](http://www.Availity.com) or through the Availity link at [providers.amerigroup.com/KS](http://providers.amerigroup.com/KS).

Electronic Claims Payer IDs:

- Emdeon (formerly WebMD) is 27514
- Capario (formerly MedAvant) is 28804
- Availity (formerly THIN) is 26375

Electronic claims may also be submitted directly to the Kansas Medical Assistance Program (KMAP) through Front-End Billing for KMAP-enrolled providers.

Mail paper claims to:

Amerigroup Kansas, Inc.

P.O. Box 61010

Virginia Beach, VA 23466

Dental services through  
Scion Dental

Providers call 1-855-812-9206

Members call 1-855-866-2627

Kansas Department of Health & Environment  
(KDHE)

Phone: 785-296-1500

KDHE: [www.kdheks.gov](http://www.kdheks.gov)

KanCare: [www.kancare.ks.gov](http://www.kancare.ks.gov)

Lab and diagnostic services

LabCorp: 1-888-522-4452

Quest Diagnostics: 1-866-697-8378

Member Eligibility Verification

Online at [providers.amerigroup.com/KS](http://providers.amerigroup.com/KS)

1-800-454-3730

Member Grievances

Call 1-800-600-4441 or submit by mail to:

Grievance Processing

Amerigroup Kansas, Inc.

P.O. Box 62509

Virginia Beach, VA 23466-2509

## Member Appeals

Appeals must be filed within 33 calendar days of receipt of the Notice of Action. You may appeal on behalf of a member with written authorization from that member.

Members may submit appeals to:

Amerigroup Kansas, Inc.  
9225 Indian Creek Parkway, Building 32  
Overland Park, KS 66210

## MultiPlan, Inc. contracted providers

To inquire about your contract status with MultiPlan call 1-866-971-7427. For all other questions, issues or service requests, call the Amerigroup Provider Services line for assistance.

## Nonemergent transportation services from Access2Care

Providers call: 1-866-410-0002  
Members call: 1-855-345-6943

## Precertification/ Notification

24/7  
Online at [providers.amerigroup.com/KS](http://providers.amerigroup.com/KS)  
By fax to 1-800-964-3627  
By phone to 1-800-454-3730

Please provide:

- Member or Medicaid ID
- Member's Social Security number if available
- Member's date of birth
- Legible name of referring provider
- Legible name of person referred to provider
- Number of visits/services
- Date(s) of service
- Diagnosis
- CPT/HCPCS codes
- Clinical information

## Provider Grievances

Submit verbal grievances to:

- Provider Services at 1-800-454-3730
- The Amerigroup Kansas health plan
- Your local Provider Relations representative

Submit a grievance in writing by letter or fax to:

Amerigroup Kansas, Inc.  
9225 Indian Creek Parkway, Building 32  
Overland Park, KS 66210  
Fax 866-494-5632

You can also appear in person at the address above to submit a grievance

Pharmacy Precertification

By phone: 1-855-201-7170  
By fax: 1-800-601-4829  
Or at [www.express-scripts.com](http://www.express-scripts.com)

Vision Services through  
Ocular Benefits

Providers call 1-866-416-0150  
Members call 1-855-866-2623

## **Provider Claims Payments**

Questions or Issues

Our Provider Experience program helps you with claims payments and issue resolution.

Just call 1-800-454-3730 and select the *Claims* prompt when you hear it.

We connect you with a dedicated resource team, called the Provider Services Unit (PSU), to ensure:

- Availability of helpful, knowledgeable representatives to assist you
- Increased first-contact, issue resolution rates
- Significantly improved turnaround time of inquiry resolution
- Increased outreach communications to keep you informed of your inquiry status

Reconsiderations

Amerigroup encourages providers to use our reconsideration process if you feel a claim was not processed correctly. We accept reconsiderations verbally by phone, online and in writing within 60 days (plus three days if mailed) of the date on the explanation of payment (EOP). A reconsideration determination letter will be sent to providers advising of the outcome.

Claims Payment Appeals

If you do not agree with Amerigroup's determination on your reconsideration request, you may file an appeal online or in writing.

We must receive your online or written appeal within 30 calendar days (plus three additional days if mailed) of the date on our reconsideration determination notice. We will send a determination on your appeal to you within 30 business days of receiving the appeal.

Submit a written payment appeal to:

Payment Appeal Unit  
Amerigroup Kansas, Inc.  
P.O. Box 61599  
Virginia Beach, VA 23466-1599

If you have exhausted the Amerigroup payment appeal process and are still not satisfied with the resolution, you have the right to a State Fair Hearing with the Office of Administrative Hearings (OAH). Please see the State Fair Hearing section of this manual for more details.

## 2. CLAIMS SUBMISSION AND ENCOUNTER PROCEDURES

You have the option of submitting claims electronically or by mail. We encourage use of electronic claims submission methods to help you:

- Receive explanations of payment and your reimbursements more quickly
- Eliminate paper waste
- Save time

### 2.1 KanCare Front-end Billing

For your convenience, you can continue sending your Kansas Medicaid claims to the state electronically. Kansas Department of Health and Environment (KDHE) will submit your claim information to each managed care organization (MCO) through daily 837 batch files. Paper claims must be submitted directly to Amerigroup.

### 2.2 Clearinghouse Submissions

You can submit electronic claims through Electronic Data Interchange (EDI). You can submit claims through:

- Emdeon (formerly WebMD) — Claim Payer ID 27514
- Capario (formerly MedAvant) — Claim Payer ID 28804
- Availity (formerly THIN) — Claim Payer ID 26375
- The state of Kansas clearinghouse

An EDI claims submission guide is located at [providers.amerigroup.com/KS](http://providers.amerigroup.com/KS).

### 2.3 ICD-10 Coding System

International Classification of Diseases, 10th Revision (ICD-10), is a diagnostic and procedure coding system endorsed by the World Health Organization (WHO) in 1990. It replaces the International Classification of Diseases, 9th Revision (ICD-9), which was developed in the 1970s. Internationally, the codes are used to study health conditions and assess health management and clinical processes; and in the United States, the codes are the foundation for documenting the diagnosis and associated services provided across health care settings.

Although we often use the term ICD-10 alone, there are actually two parts to ICD-10:

- ICD-10-CM (Clinical Modification) used for diagnosis coding, and
- ICD-10-PCS (Procedure Coding System) used for inpatient hospital procedure coding; this is a variation from the WHO baseline and unique to the United States.

ICD-10-CM replaced the code sets, ICD-9-CM, Volumes 1 and 2 for diagnosis coding, and ICD-10-PCS will replace ICD-9-CM, Volume 3 for inpatient hospital procedure coding.

### 2.4 Web-based Claims Submissions

Submit claims on our website by:

- Entering claims on a preformatted CMS-1500 and CMS-1450/UB04 claim template
- Uploading a HIPAA-compliant ANSI 837 5010 claim transaction

To start the electronic claims submission process or if you have questions, please contact our EDI Hotline at 1-800-590-5745.

### 2.5 Paper Claims Submission

All paper claims are to be submitted directly to Amerigroup:

Amerigroup Kansas, Inc.  
P.O. Box 61010  
Virginia Beach, VA 23466

CMS-1500 and CMS-1450/UB04 forms are available on our provider website at [providers.amerigroup.com/KS](http://providers.amerigroup.com/KS).

## **2.6 Encounter Data**

You must submit encounter data within the timely filing periods outlined in the Claims Adjudication section of this manual through:

- EDI submission methods
- CMS-1500 (08-05) or 1450/UB-04 claim form
- Other arrangements that are approved by Amerigroup

Encounter data are the following required pieces of information:

- Member name (first and last name)
- Member ID
- Member date of birth
- Provider name according to contract
- Amerigroup provider number
- Coordination of benefit information
- Date of encounter
- Diagnosis code
- Types of services provided (using current procedure codes and modifiers if applicable)
- Provider tax ID number
- NPI/API number

Our Utilization and Quality Improvement staff monitors compliance, coordinates it with the medical director and then reports to the QMC on a quarterly basis. Lack of compliance will result in:

- Training
- Follow-up audits
- Even termination

## **2.7 Claims Adjudication**

We are dedicated to providing timely adjudication of claims. We process all claims according to generally accepted claims coding and payment guidelines defined by the CPT-4 and ICD-10 manuals.

You must use HIPAA-compliant billing codes when billing Amerigroup electronically or on paper. When billing codes are updated, you are required to use appropriate replacement codes for submitted claims. We will reject claims submitted with noncompliant billing codes.

We reserve the right to use code-editing software to determine which services are considered part of, incidental to or inclusive of the primary procedure.

### **Timely Filing**

Providers should refer to their specific provider contract for timely filing periods. Generally, paper and electronic claims must be filed within 180 days. For any corrected claim, or other rebilling, the filing limit is 365 days.

Timely filing periods begin from the date of discharge for inpatient services and from date of service for outpatient/physician services. Timely filing requirements are defined in your provider agreement; please refer to it for detailed requirements.

There are exceptions to the timely filing requirements. They include:

- Cases of coordination of benefits/subrogation. For cases of coordination of benefits/subrogation, the time frames for filing a claim will begin on the date of the third party's resolution of the claim.
- Cases where a member has retroactive eligibility. In situations of enrollment in Amerigroup with a retroactive eligibility date, the time frames for filing a claim will begin on the date that Amerigroup receives notification from the enrollment broker of the member's eligibility/enrollment.

We will deny claims submitted after the filing deadline.

### **Documentation of Timely Claim Receipt**

The following information will be considered proof that a claim was received timely. If the claim is submitted:

- By U. S. mail (first class, return receipt requested or by overnight delivery service): the provider must provide a copy of the claim log that identifies each claim included in the submission.
- Electronically: the provider must provide the clearinghouse assigned receipt date from the reconciliation reports.
- By hand delivery: the provider must provide a claim log that identifies each claim included in the delivery and a copy of the signed receipt acknowledging the hand delivery.

The claims log maintained by providers must include the following information:

- Name of claimant
- Address of claimant
- Telephone number of claimant
- Claimant's federal tax identification number
- Name of addressee
- Name of carrier
- Designated address
- Date of mailing or hand delivery
- Subscriber name
- Subscriber ID number
- Patient name
- Date(s) of service/occurrence
- Total charge
- Delivery method

### **Good Cause**

If the claim or claim dispute includes an explanation for the delay or other evidence that establishes the reason, Amerigroup will determine good cause based primarily on that statement or evidence and/or if the evidence leads to doubt about the validity of the statement. Amerigroup will contact the provider for clarification or additional information necessary to make a good cause determination.

Good cause may be found when a physician or supplier claim filing delay was due to:

- Administrative error: incorrect or incomplete information furnished by official sources (e.g., carrier, intermediary, CMS) to the physician or supplier
- Incorrect information furnished by the member to the physician or supplier resulting in erroneous filing with another care management organization plan or with the state

- Unavoidable delay in securing required supporting claim documentation or evidence from one or more third parties despite reasonable efforts by the physician/supplier to secure such documentation or evidence
- Unusual, unavoidable or other circumstances beyond the service provider's control that demonstrate the physician or supplier could not reasonably be expected to have been aware of the need to file timely
- Destruction or other damage of the physician's or supplier's records, unless such destruction or other damage was caused by the physician's or supplier's willful act of negligence

## **2.8 Claims for Newborns**

Claims for newborn services billed under the mother's member ID number may be suspended for 45 days pending our receipt of the newborn's member ID number from the state. If Amerigroup receives a newborn ID within 45 days of the newborn's date of birth, the original claim submitted under the mother's ID will be denied. The provider will be notified that a new claim will need to be submitted using the newborn's member ID number.

If Amerigroup does not receive a newborn ID within 45 days of the newborn's date of birth, the claim will be processed under the mother's member ID number.

Newborn services are considered procedure codes, which specifically state "newborn" in the code description according to the CPT manual or revenue codes 170- 179 billed with a newborn diagnosis code.

When billing newborn services for a newborn that does not have a member ID number, providers must use "Newborn," "Baby Girl" or "Baby Boy" in the first name field and enter the last name. Providers must use the newborn's date of birth and the mother's beneficiary ID number.

## **2.9 Clean Claims Payments**

A clean claim is a claim that can be processed without obtaining additional information from the provider of the service or from a third party. It includes a claim with errors originating in a state's claims system. It does not include a claim from a provider who is under investigation for fraud or abuse or a claim under review for medical necessity.

Once a claim has been determined to be nonfraudulent, it must be resubmitted to be considered a clean claim.

We will adhere to and adjudicate clean claims to a paid or denied status within:

- 100 percent of all clean claims, including adjustments processed and paid or processed and denied within 30 days of receipt
- 99 percent of all nonclean claims, including adjustments processed and paid or processed and denied within 60 days of receipt
- 100 percent of all claims, including adjustments processed and paid or processed and denied within 90 days of receipt

## **Nursing Facilities (NF)**

We will adhere to and adjudicate clean claims to a paid or denied status as follows:

- Pay 90 percent of clean claims within 14 days
- Pay 99.5 percent of clean claims within 21 days

We produce and mail an EOP five times a week. It shows the status of each claim that has been adjudicated during the previous claim cycle. If we do not receive all of the required information to process your claim as clean, a request for the missing information will appear on your EOP. Once we have received the requested information, we will process the claim within the time frames outlined above.

We will return electronic claims that are determined to be unclear to the clearinghouse that submitted the claim.

### **2.10 Claims Status**

You can check the status of claims on our provider self-service website (Avality) or by calling our Provider Services team. You can also use the claims status information for accepted and rejected claims that were submitted through a clearinghouse.

If we do not have the claim on file, resubmit your claim within the timely filing requirements. If filing electronically, check the confirmation reports for acceptance of the claim that you receive from your EDI or practice management vendor.

### **2.11 Coordination of Benefits and Third-party Liability**

We follow Kansas-specific guidelines and all federal regulations regarding coordination of benefits, third-party liability (TPL) and medical subrogation. We use covered medical and hospital services whenever available or other public or private sources of payment for services rendered to our members.

TPL refers to any individual, entity or program that may be liable for all or part of a member's health coverage. The state is required to take all reasonable measures to identify legally liable third parties and treat verified TPL as a resource of each plan member.

Amerigroup takes responsibility for identifying and pursuing TPL for our members. We will make best efforts to identify and coordinate with all third parties against whom members may have claims for payments or reimbursements for services. These third parties may include Medicare or any other group insurance, trustee, union, welfare, employer organization or employee benefit organization, including preferred provider organizations or similar type organizations, any coverage under governmental programs, and any coverage required to be provided for by state law.

When TPL resources are available to cover the costs of trauma-related claims and medical services provided to Medicaid members, we will deny the claim and redirect you to bill the appropriate insurance carrier (unless certain pay and chase circumstances apply — see below). Or if we do not become aware of the resource until after payment for the service was rendered, we will pursue post-payment recovery of the expenditure. You must not seek recovery in excess of the Medicaid payable amount.

The pay and chase circumstances are:

- When the services are for preventive pediatric care, including KAN Be Healthy (EPSDT)
- If the claim is for prenatal care

Our subrogation vendor handles the filing of liens and settlement negotiations both internally and externally.

If you have any questions regarding paid, denied or pended claims, please call Provider Services at 1-800-454-3730.

### **The Provider's Role**

#### **Gathering TPL Information**

Since you have direct contact with our members, you are the best source of timely third-party liability (TPL) information. The contribution you can make in the TPL area is very significant.



You have an obligation to investigate and report the existence of other insurance or liability. Cooperation is essential to the functioning of the KMAP system and to ensure prompt payment. At the time you obtain billing information from the beneficiary, you should also determine if additional insurance resources exist. When they exist, these resources must be identified on the claim form in order for the claims to adjudicate properly.

Remember, if a specific insurance coverage is on file for a member, proof of termination, denial or exhaustion of benefits must be submitted from that carrier before the file can be corrected.

### **Billing TPL**

Per 42 CFR §433.139(b), if the probable existence of TPL (such as Medicare or health insurance) is established at the time a claim is filed, Amerigroup must reject the claim and return it to the provider for a determination of the amount of liability. This means that the provider must attempt to bill the other insurance prior to filing the claim to Amerigroup.

The provider must follow the rules of the primary insurance plan (such as obtaining prior authorization and filing within the primary insurance plan's timely filing period) or the related Amerigroup claim will be denied. It is important that providers maintain adequate records of third-party recover efforts for a period of time not less than five years. These records, like all other records, are subject to audit by Health and Human Services, the Centers for Medicare and Medicaid Services (CMS), the state Medicaid agency, or any of their representatives.

Kansas requires beneficiary compliance with the rules of any insurance plan primary to KanCare. If the member does not cooperate and follow the rules of the insurance plan (such as staying in network, obtaining a referral, obtaining proper prior authorization), the related Amerigroup claim will be denied. CMS does not allow federal dollars to be spent if a member with access to other insurance does not cooperate or follow the applicable rules of his or her other insurance plan.

You must not bill Amerigroup for the other insurance provider write-off amount (sometimes referred to as contractual write-off amount). Amerigroup should only be billed for the remaining patient liability amount, if any.

When a service is not covered by a beneficiary's primary insurance plan, a blanket denial letter can be requested from the insurance carrier. From the insurance carrier, the provider needs to request a letter, on company letterhead, stating the service is not covered by the insurance plan covering the member.

You may not charge our members, or any financially responsible relative or representative of the member any amount in excess of the Amerigroup paid amount. Section 1902(a) (25)(C) of the Social Security Act prohibits Medicaid providers from directly billing Medicaid beneficiaries. Section 1902(g) allows for a reduction of payments otherwise due the provider in an amount equal to up to three times the amount of any payment sought to be collected by that person in violation of subsection (a)(25)(C).

### **Long-Term Care Insurance**

When a long-term care (LTC) insurance policy exists, it must be treated as TPL and be cost avoided.

If you discover an insurance policy that should have paid primary to Medicaid after receiving payment from Medicaid, you must bill that insurance carrier and attempt to collect payment.

Amerigroup cannot be rebilled if a claim has crossed over from Medicare to Medicaid resulting in a zero paid claim because a zero paid claim cannot be adjusted. When you allow a Medicare claim to cross over to Amerigroup you are agreeing to accept Medicaid payment as payment in full. In many cases, the claim will result in a zero Amerigroup payment because Medicare's payment is greater than the Amerigroup allowed amount. If you wish to pursue potential third parties after Medicare but before filing Medicaid claims, notify Amerigroup

that you do not want any Medicare claims to cross over. You can balance bill Amerigroup but are not required to if Medicare and the other third-party payments received exceed the Amerigroup allowed amount.

### **Medicare-Related Claims**

- When a patient is eligible for Medicare payment, providers must submit claims to Medicare first (unless the claim is for Medicare exempt services). If a patient is 65 or over, has chronic renal disease, or is blind or disabled, an effort must be made to determine Medicare eligibility.
- You cannot seek to collect from Amerigroup member, or any financially responsible relative or representative of the member, the difference between the Medicare/Medicaid allowable and your billed charges (S.S.A. §1902(a)(25)(C)).
- You should bill Medicare-noncovered and Medicare-covered services separately to ensure proper reimbursement. Medicare-covered services should be billed to Medicare and automatically crossed over.
- Services not covered by Medicare should not be billed to Medicare but instead directly to Amerigroup or the other primary payer.
- If a clear determination cannot be made whether the resources are related to Medicare (including Medicare replacement plans or Part C Advantage Plans) or other health insurance, the claim will not be processed but will be returned requesting clarification.

### **Claims Automatically Crossed Over**

Medicare Part B will automatically cross over claims for professional services when the following criteria are met:

- You file Medicare claims to the appropriate regional carrier for Kansas.
- The services are covered by Medicare.
- The member's Amerigroup ID number is identified on the Medicare claim form in the "Other Insurance" field (Box 9a on the CMS-1500 claim form).
- The "Accept Assignment" field (Box 27 on the CMS-1500 claim form) is checked "yes."

You are notified on the explanation of Medicare benefits (EOMB) that the claim was automatically crossed over for Medicaid processing.

### **Claims Not Automatically Crossed Over**

- Claims billed to Medicare carriers other than the appropriate regional Medicare contractor for Kansas.
- Claims denied by Medicare.
- Claims the fiscal agent is unable to find a provider number that cross matches.

When this occurs, bill Amerigroup using the following procedures:

- Submit a claim to Amerigroup
- Attach Medicare's EOMB or equivalent

In order for Medicare-related claims to process correctly, the Medicare EOMB attached to the claim must be specific to the member and match the codes and units.

### **Pricing Algorithm**

- Amerigroup processes professional and institutional Medicare-related claims using the same algorithm calculation applied to other third-party claims. If Medicare paid more than the amount allowed by Amerigroup for that service, no additional reimbursement will be made. If a service is not covered under Amerigroup, no allowable amount will be computed for the service.
- After calculation of the total amount allowed by Amerigroup for the claim, comparison of what Amerigroup allowed to the Medicare-allowed will be made (Medicare paid plus coinsurance plus deductible).

Noncovered Medicare services are not included in this algorithm. These claims are processed using standard Amerigroup pricing methodologies.

- When the amount allowed by Amerigroup is greater than Medicare's paid amount (not including patient liability), Amerigroup will make a payment. Amerigroup will be the lesser of the:
  - Patient liability amount.
  - Difference between the amount allowed by Amerigroup and the Medicare paid amount.

### **Exceptions to the Usual Pricing**

When the amount allowed by Amerigroup is equal to or less than Medicare's allowed amount, Amerigroup will not make a payment unless the product or provider type has an exception to the usual pricing.

Rural Health Center, Federally Qualified Health Center and Indian Health Center claims are exempt from the other insurance pricing algorithm applicable to other provider types. The lesser allowed amount (Medicaid versus other insurance) should not be taken into consideration. Reimbursement should equal the Medicaid allowed amount minus other insurance payment. This includes Medicare crossover claims as well. Note that the above disclaimer is not Medicare specific but applies across other types of TPL as well.

If both Medicare Part A and B made payment on the same claim, the Medicare Part A payment is processed under the normal algorithm. The Part B payment should then be subtracted as other insurance payment.

### **Part B Only**

Billing for members who have no Part A due to lack of eligibility or because benefits are exhausted:

- If the member has no Part A but does have Part B and is admitted to the hospital through the emergency room or outpatient department, these emergency room, outpatient and selected inpatient ancillary services must be billed to Medicare on form SSA 1483. Amerigroup will process all Part A nonpayable services billed to Medicaid on the UB-04 with appropriate documentation demonstrating Medicare's refusal to pay due to no Part A benefits.
- Payment must be made for members for all Amerigroup covered services, less the Medicare-allowed amounts, spend down, copayment and other third-party payments but no more than the Amerigroup maximum-allowable specified coinsurance and/or deductible amounts.
- Charges for emergency room or outpatient services are billed to Medicare on form SSA 1483 for patients with Part B only. Amerigroup will pay up to the maximum allowable for covered services, less the amount paid by Medicare, up to the deductible and/or coinsurance amount.
- If Part A Medicare benefits have been exhausted and the patient is still receiving care, bill Part B Medicare for inpatient benefits.
- Once Medicare Part A regular inpatient benefits are exhausted, dual-eligible beneficiaries (those who have both Medicaid and Medicare) can only receive Medicaid payment if they have already used their lifetime reserve (LTR) days or they elect to use their LTR days. An Amerigroup member must make a written election not to use LTR days and cannot be "deemed" to have elected not to use LTR days. If a beneficiary makes a written election not to use LTR days after the regular inpatient days are exhausted, Amerigroup will not issue payment for any part of the inpatient stay which would have been covered if the member had elected to use the LTR days.
- After making a written election not to use LTR days, a member can still decide to use LTR days. Amerigroup will accept the written election form outlined by Medicare in Chapter 5 of the Medicare Benefit Policy Manual.

### **How to File When Medicare Denies Payment**

- Attach a copy of the Medicare EOMB/RA showing denial of the service(s) being billed. If services are over 12 months old, original timely filing must be proven. If services are over 24 months old, 12-month timely filing

must be proven and Amerigroup must be billed within 30 days of Medicare's denial in order for claim payment to be considered.

### **Paper Submission**

Submission of coordination of benefits/third-party liability information:

Submit a Claim Correspondence form, a copy of your EOP and the COB/TPL information to:

Claims Correspondence  
Amerigroup Kansas, Inc.  
P.O. Box 61599  
Virginia Beach, VA 23466-1599

### **EDI Submission Process**

Electronic submitters are not required to submit paper documentation to support other insurance payment or denial. However, adequate documentation must be retained in the patient's file and is subject to review.

Documentation of proper payment of denial of TPL is considered acceptable if it corresponds with the member name, dates of service, charges and TPL payment listed on your claim. The only acceptable forms of documentation proving that insurance was billed first are a remittance advice (RA) or explanation of benefits (EOB) letter from the other insurer.

If a beneficiary has other applicable insurance, providers who bill electronic need to submit the claim adjustment reason code and remittance advice remark code provided by the other insurance company on their EOMB or RA for all affected services.

Policy information listed below should be entered with the TPL policy information available at the time of the claim:

- Policy number – Enter the policy number of the other insurance
- Plan name – Enter the name of the plan under which the policyholder has coverage
- Date adjudicated – Enter the appropriate date from the other insurance carrier's EOB
- Policyholder's relationship – Relationship of the policyholder to the beneficiary
- Insurance type
- Total allowed amount of other carrier
- Amount paid by other carrier
- Amounts applied to deductible
- Amount applied to coinsurance and/or copay
- Any denied or noncovered services explanation codes

### **Medicare Crossover**

- Medicare paid date – Enter the date of the explanation of Medicare benefits (EOMB) that corresponds to the Medicare claim for the member.
- Coinsurance – Enter the amount applied to the member's Medicare coinsurance based on the Medicare EOMB.
- Deductible – Enter the amount applied to the beneficiary's Medicare deductible based on the Medicare EOMB.
- Psych amount – Enter the amount reported on the Medicare EOMB as the psych amount.
- Allowed amount
- Paid amount – Enter the amount Medicare previously paid for the same services now being billed.

## 2.12 Reimbursement Policies

Reimbursement policies serve as a guide to assist you with accurate claims submissions and outline the basis for reimbursements when services are covered by the member's Amerigroup plan. The determination that a service, procedure, item, etc. is covered under a member's benefit plan is not a determination that you will be reimbursed. Services must meet authorization and medical necessity guidelines appropriate to the procedure and diagnosis, as well as the member's state of residence.

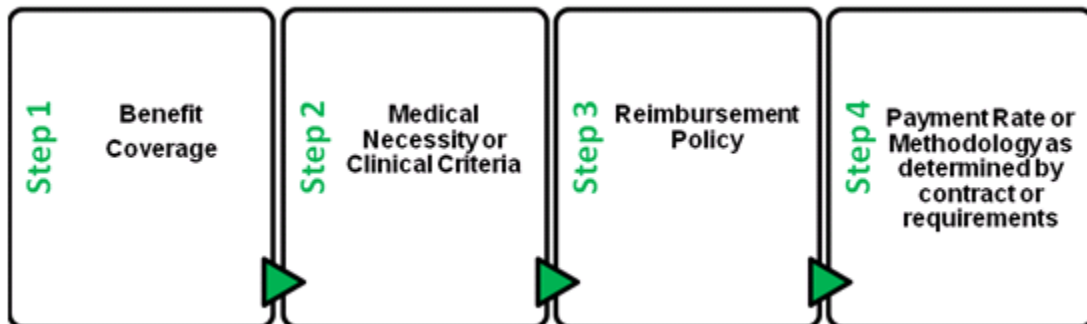
You must follow proper billing and submission guidelines. You are required to use industry standard, compliant codes on all claims submissions. Services should be billed with Current Procedure Terminology (CPT) codes, Healthcare Common Procedure Coding System (HCPCS) codes and/or revenue codes. The codes denote the services and/or procedures performed. The billed code(s) are required to be fully supported in the medical record and/or office notes. Unless otherwise noted within the policy, our policies apply to both participating and nonparticipating providers and facilities.

The Amerigroup reimbursement policies are based on nationally accepted industry standards and coding principles. These policies may be superseded by mandates in provider or state contracts or state, federal or CMS requirements. System logic or set up may prevent the loading of policies into the claims platforms in the same manner as described; however, Amerigroup strives to minimize these variations.

We reserve the right to review and revise our policies periodically when necessary. When there is an update, we will publish the most current policies to our provider website under the *Quick Tools* menu.

### Reimbursement Hierarchy

Claims submitted for payments must meet all aspects of criteria for reimbursements. The reimbursement hierarchy is the order of payment conditions that must be met for a claim to be reimbursed. Conditions of payment could include benefits coverage, medical necessity, authorization requirements or stipulations within a reimbursement policy. Neither payment rates nor methodologies are considered to be conditions of payments.



### Review Schedule and Updates

Reimbursement policies undergo reviews every two years for updates to state contracts or state, federal or CMS requirements. Additionally, updates may be made at any time if we are notified of a mandated change or due to an Amerigroup business decision. When there is an update, we will publish the most current policies to our provider self-service site.

### Reimbursement by Code Definition

Amerigroup allows reimbursements for covered services based on their procedure code definitions or descriptors, as opposed to their appearance under particular CPT categories or sections, unless otherwise noted by state or provider contracts or state, federal or CMS requirements. There are seven CPT sections:

1. Evaluation and management

2. Anesthesia
3. Surgery
4. Radiology (nuclear medicine and diagnostic imaging)
5. Pathology and laboratory
6. Medicine
7. Temporary codes for emerging technology, services or procedures

At times, procedure codes are located in particular CPT categories when those procedures may not, as a general understanding, be classified within that particular category (e.g., venipuncture is located in the CPT Surgical Section but is not considered to be a surgical procedure).

### **Overpayment Process**

Refund notifications may be identified by two entities: Amerigroup and its contracted vendors or the providers. Amerigroup researches and notifies the provider of an overpayment requesting a refund check. Once an overpayment has been identified by Amerigroup, Amerigroup will notify the provider of the overpayment. The overpayment notification will include instructions on how to refund the overpayment.

### **Overpayment of Claims**

The provider may also identify an overpayment and proactively submit a refund check to reconcile the overpayment amount.

There are two options for providers to notify Amerigroup should there be an overpayment of claims.

- **Refund Notification Form** – This is used if you want to issue a refund check immediately. You would fill out the form and send it to the address listed along with a check.
- **Recoupment Notification Form** – This is used when you want to alert us to an overpayment, but don't want to issue a check immediately. You would fill this out, send to the address listed and then our recoupment department will review it and send you a recoupment request.

Both of these forms can be found on our website at [providers.amerigroup.com/KS](http://providers.amerigroup.com/KS) under the Forms section.

In instances where we are required to adjust previously paid claims to adhere to a new published rate, we will initiate a reconciliation of the affected claims. As such, we will determine the cumulative adjusted reimbursement amount based on the new rates. In the event the outcome of this reconciliation results in a net amount owed to us, we will commence recovery of such amounts through an offset against future claims payments. Such recoveries are not considered part of the overpayment recovery process described above or in the provider agreement.

Changes addressing the topic of overpayments have taken place with the passage of the Patient Protection and Affordable Care Act (PPACA), commonly known as the Healthcare Reform Act.

The provision directly links the retention of overpayments to false claim liability. The language of 42 U.S.C.A. § 1320a-7k makes explicit that overpayments must now be reported and returned to states or respective MCOs within 60 days of identification of the overpayment or by the date any corresponding cost report is due, whichever is later. After 60 days, the overpayment is considered a false claim, which triggers penalties under the False Claims Act, including treble damages. In order to avoid such liability, health care providers and other entities receiving reimbursement under Medicare or Medicaid should implement policies and procedures on reporting and returning overpayments that are consistent with the requirements in the PPACA .

The provision entitled "Reporting and Returning Overpayments – Deadline for Reporting and Returning Overpayments," codified at 42 U.S.C.A. § 1320a-7k, clarifies the uncertainty left by the 2009 Fraud Enforcement

and Recovery Act. This provision of the HealthCare Reform Act applies to providers of services, suppliers, Medicaid managed care organizations, Medicare Advantage organizations and Medicare Prescription Drug Program sponsors. It does not apply to members.

## **2.13 Billing Members**

### **Advance Beneficiary Notice**

The KanCare member can be held responsible for payment of common services and situations. Members can be billed only when program requirements have been met and the provider has informed the member in advance and in writing. The provider must notify the member in advance if a service will not be covered. To ensure the member is aware of his or her responsibility, the provider has the option of obtaining a signed Advanced Beneficiary Notice (ABN) from the member prior to providing services. A verbal notice is not acceptable. Posting the ABN in the office is not acceptable.

An ABN form is available at the end of this provider manual section.

For services where there are normally no face-to-face contact points between the member and the provider (e.g., lab and radiology services), the written ABN signed annually by the member with the referring provider is an appropriate notification of responsibility for payment of noncovered charges.

If an ABN is executed with a member, examples of services the member could be liable for include:

- Services the member was not eligible for when provided
- Services Medicaid does not cover, unless both of the following apply:
  - Member is a Qualified Medicare Beneficiary (QMB)
  - Service is covered by Medicare
- When other insurance does not reimburse the provider because there was lack of authorization
- Abortion, unless continuation of the pregnancy will endanger the life of the mother, or when pregnancy is the result of rape or incest
- Any services related to and performed following a noncovered abortion
- Acupuncture
- Community mental health center services and alcohol and drug abuse treatment services provided outside the boundaries of Kansas regardless of being within 50 miles of the state border
- Cosmetic surgery
- Services related to and performed following a noncovered cosmetic surgery
- Court appearances, telephone conferences/therapy
- Educational/instructional services
- Hospital charges incurred after the physician has discharged the patient from inpatient care
- Hypnosis, biofeedback or relaxation therapy
- Infertility services (any tests, procedures or drugs related to infertility services)
- Occupational therapy supplies
- Perceptual therapy
- Psychotherapy for patients whose only diagnosis is intellectual or developmental disabilities
- Services for the sole purpose of pain management
- Services provided in cases of developmental delay for purposes of "infant stimulation"
- Services which are pioneering or experimental, and complications from such services
- Services of social workers, team or therapy coordinators, and speech therapists in private practice (unless member is a QMB)
- Transplant surgery
  - Cyclosporine (except when prior authorized, following kidney, liver and bone marrow transplants)

- All services related solely to noncovered transplant procedures
- Transplant surgery, in some cases, is a covered service for members; call Provider Services for assistance with transplant questions
- Treatment for obesity, with the exception of
  - Bariatric surgery (when criteria is met)
  - Orlistat (Xenical) and sibutramine (Meridia) being covered with prior authorization for individuals with a body mass index (BMI) greater than 30 or greater than 27 with comorbidity
- Vocational therapy, employment counseling, marital counseling/therapy and social services
- Voluntary sterilizations which do not meet federal requirements
- The private room difference in a hospital setting
- Special diet in the hospital when ordered per the member's request

Providers are not to charge a member for services denied for payment by Amerigroup because the provider failed to meet a program requirement including precertification (prior authorization).

#### **2.14 Advanced Beneficiary Notice**

You may bill a member for a service that has been denied as not medically necessary or not a covered benefit only if both of the following conditions are true:

- The member requests the specific service or item
- The provider obtains and keeps a written acknowledgement statement signed by the member and the provider stating:

“I understand that, in the opinion of (provider’s name), the services or items that I have requested to be provided to me on (dates of service) may not be covered under Amerigroup as being reasonable and medically necessary for my care or are not a covered benefit. I understand that Amerigroup has established the medical necessity standards for the services or items that I request and receive. I also understand that I am responsible for payment of the services or items I request and receive if these services or items are determined to be inconsistent with the Amerigroup medically necessary standards for my care or are not a covered benefit.”

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

#### **Members Hold Harmless**

Federal regulations stipulate that Medicaid members are not to be held liable for:

- MCO’s debts in the event of the entity’s insolvency.
- Covered services provided to the members for which:
  - The State does not pay for the MCO.
  - The State or the MCO does not pay the individual or health care provider that furnishes the services under a contractual, referral or other arrangement.
- Payments for Covered Services furnished under a contract, referral or other arrangement, to the extent that those payments are in excess of the amount that the member would owe if the MCO provided the services directly.



### 3. PROVIDER GRIEVANCE, PAYMENT RECONSIDERATION AND PAYMENT APPEAL PROCEDURES

#### 3.1 Provider Grievance Procedures

You can submit verbal or written grievances. Supporting documentation should accompany the grievance. Grievances are resolved fairly and are consistent with our policies and covered benefits. You will not be penalized for filing a grievance.

#### 3.2 Verbal Grievance Process

Submit verbal grievances to:

- Provider Services at 1-800-454-3730
- The Amerigroup Kansas health plan
- Your local Provider Relations representative

All provider calls will be answered immediately during normal business hours. Inquiries will be resolved and/or results will be communicated to the provider within 30 business days of receipt. If the provider requests or the contractor believes additional time is needed beyond 30 days to resolve the grievance, the MCO may extend the time frame by up to 14 calendar days.

You can also appear in person at the address above to submit a grievance.

#### 3.3 Written Grievance Process

Submit a grievance in writing by letter or fax to:

Amerigroup Kansas, Inc.  
9225 Indian Creek Parkway, Building 32  
Overland Park, KS 66210  
Fax: 866-494-5632  
Attn: Provider Relations – Provider Grievance

You can also appear in person at the address above to submit a grievance.

#### 3.4 Claims Payment Inquiries

Our Provider Experience program helps you with claims payment and issue resolution. Just call 1-800-454-3730 and select the *Claims* prompt within our voice portal. We connect you with a dedicated resource team, called the Provider Service Unit (PSU), to ensure:

- Availability of helpful, knowledgeable representatives to assist you
- Increased first-contact, issue resolution rates
- Significantly improved turnaround time of inquiry resolution
- Increased outreach communication to keep you informed of your inquiry status

The PSU is available to assist you in determining the appropriate process to follow for resolving your claim issue.

#### Claims Correspondence versus Payment Appeal

The following table provides examples of claim-related issues that should not go through the payment reconsideration or appeal process. These are common claim issues along with guidance on the most efficient way to resolve the issue.

Type of Issue	What Do I need to Do?
Rejected Claim(s)	Use the <b>EDI Hotline</b> at 1-800-590-5745 when your claim was submitted electronically but was never paid or was rejected. We're available to assist you with setup questions and help resolve submission issues or electronic claims rejections.
EOP Requests for Supporting Documentation (Sterilization/Hysterectomy/Abortion Consent Forms, itemized bills, and invoices)	Submit a claim correspondence form, a copy of your EOP and the supporting documentation to: Claims Correspondence Amerigroup Kansas, Inc. P.O. Box 61599 Virginia Beach, VA 23466-1599
EOP Requests for Medical Records	Submit a Claim Correspondence form, a copy of your EOP and the medical records to: Claims Correspondence Amerigroup Kansas, Inc. P.O. Box 61599 Virginia Beach, VA 23466-1599
Need to submit a corrected claim due to errors or changes on original submission	Submit a Claim Correspondence form and your corrected claim to: Claims Correspondence Amerigroup Kansas, Inc. P.O. Box 61599 Virginia Beach, VA 23466-1599  Clearly identify the claim as corrected. We cannot accept claims with handwritten alterations to billing information. We will return claims that have been altered with an explanation of the reason for the return. Provided the claim was originally received timely, a corrected claim must be received within 365 days of the date of service. In cases where there was an adjustment to a primary insurance payment and it is necessary to submit a corrected claim to Amerigroup to adjust the OHI payment information, the timely filing period starts with the date of the most recent OHI EOB.
Submission of coordination of benefits/third-party liability information	Submit a Claim Correspondence form, a copy of your EOP and the COB/TPL information to: Claims Correspondence Amerigroup Kansas, Inc. P.O. Box 61599 Virginia Beach, VA 23466-1599
Emergency Room Payment Review	Submit a Claim Correspondence form, a copy of your EOP and the medical records to: Claims Correspondence Amerigroup Kansas, Inc. P.O. Box 61599 Virginia Beach, VA 23466-1599

### **3.5 Claim Payment Reconsiderations and Appeals**

A claim payment reconsideration or appeal is any dispute between you and Amerigroup for reason(s), including:

- Contractual payment issues
- Inappropriate or unapproved referrals initiated by providers
- Retrospective review
- Disagreements over reduced or zero-paid claims
- Authorization issues
- Timely filing issues
- Other health insurance denial issues
- Claim code editing issues
- Duplicate claim issues
- Retro-eligibility issues
- Experimental/investigational procedure issues
- Claim data issues

You will not be penalized for filing a reconsideration or appeal. No action is required by the member.

#### **Claim Payment Reconsideration**

Amerigroup encourages providers to use our claims payment reconsideration process if you feel a claim was not processed correctly.

We accept claim payment reconsiderations in writing, verbally and through our provider web portal within 63 calendar days from the date on the explanation of payment (EOP).

Amerigroup will make every effort to resolve the claims payment reconsideration within 30 business days of receipt. We will send you our decision in a determination letter, which will include:

- a) A statement of the provider's reconsideration request
- b) A statement of what action Amerigroup intends to take or has taken
- c) The reason for the action
- d) Support for the action including applicable statutes, regulations, policies, claims, codes or provider manual references
- e) An explanation of the provider's right to request a claim payment appeal within thirty-three (33) days of the date of the reconsideration determination letter
- f) An address to submit the claim payment appeal
- g) A statement that the completion of the Amerigroup claim payment appeal process is a necessary requirement before requesting a state fair hearing

Note: If the decision results in a claim adjustment, the payment and explanation of payment (EOP) will be sent separately.

If additional information is required to make a determination, the determination date may be extended by 30 additional business days. We will mail you a written extension letter before the expiration of the initial 30 business days.

Amerigroup will consider reimbursement of a claim which has been denied due to failure to meet timely filing if: 1) you can provide documentation that the claim was submitted within the timely filing requirements, or 2) demonstrate good cause exists.

## **Claim Payment Appeal**

If you are dissatisfied with the outcome of a claims payment reconsideration determination, you may submit a claim payment appeal. Providers must complete the claims payment reconsideration process before submitting a claim payment appeal.

We accept claim payment appeals only in writing or through our provider web portal within thirty-three (33) calendar days of the written date of notice of the claims reconsideration determination.

Claim payment appeals received more than thirty-three (33) calendar days after the claims reconsideration determination letter will be considered untimely and will be denied. The claims appeal determination letter will include:

- a) A statement of the provider's claim payment appeal request
- b) A statement of what action Amerigroup intends to take or has taken
- c) The reason for the action
- d) Support for the action including applicable statutes, regulations, policies, claims, codes or provider manual references
- e) A statement about how to submit a state fair hearing

Note: If the decision results in a claim adjustment, the payment and EOP will be sent separately.

If a claim payment appeal requires clinical expertise, it will be reviewed by appropriate clinical Amerigroup professionals.

If the claim payment determination requires additional information to resolve, the determination date may be extended by thirty (30) business days. A written extension letter will be sent to you before the expiration of the initial thirty-three (33) calendar day claims appeal determination period.

## **How to Submit Reconsiderations and Appeals**

**Verbal submissions (reconsiderations only):** Verbal submissions may be submitted by calling the Amerigroup Provider Service Unit (PSU) at 1-800-454-3730.

**Secure provider web portal submissions (both reconsideration and appeals):** Amerigroup can receive reconsideration and appeals via the Availity Payment Appeal Tool at [www.Availity.com](http://www.Availity.com).

When inquiring on the status of a claim, a dispute selection box will display. Once this box is clicked, a Web form will display for you to complete and submit. You will receive immediate acknowledgement of your submission once the form is fully completed. Supporting documentation can be uploaded by the use of the attachment feature on the Web dispute form and will attach to the form when submitted.

**Written submissions (both reconsideration and appeals):** Written reconsiderations and appeals should be mailed to:

Amerigroup Payment Appeals  
P.O. Box 61599  
Virginia Beach, VA 23466-1599

## **Required Documentation for Claims Payment Reconsideration and Appeals submissions**

Amerigroup requires the following information when submitting a claims payment reconsideration or appeal:

- Your name, address, phone number, email and either your NPI or TIN
- The member's name and their Amerigroup or Medicaid ID number

- A listing of disputed claims which should include the Amerigroup claim number and the date(s) of service(s)
- Supporting statements and documentation
- Please submit written appeals on the *Appeal Request* form located at [https://providers.amerigroup.com/ProviderDocuments/KSKS\\_ClaimPaymentAppeal.pdf](https://providers.amerigroup.com/ProviderDocuments/KSKS_ClaimPaymentAppeal.pdf).

### **State Fair Hearing Rights**

Providers have the right to a State Fair Hearing. You must exhaust Amerigroup's entire appeal process prior to submitting a state fair hearing request. The request must be submitted so it is received within 33 calendar days of the appeals letter with our final decision on your appeal.

Providers may file State Fair Hearing requests with the Office of Administrative Hearings. You may fax the request to 785-296-4848 or mail it to:

Office of Administrative Hearings  
1020 S. Kansas Ave.  
Topeka, KS 66612-1327

Amerigroup will also be glad to help you submit a State Fair Hearing request. You may submit requests to Amerigroup via telephone, fax, voicemail, email, written communication or in person. Please mail requests to:

Amerigroup Kansas, Inc.  
Attn: State Fair Hearing  
9225 Indian Creek Parkway, Building 32  
Overland Park, KS 66210

You may also call us at 1-800-454-3730, fax us at 1-844-664-7183, email us at [ks1providersupport@amerigroup.com](mailto:ks1providersupport@amerigroup.com) or appear in person at 9225 Indian Creek Parkway, Building 32, Overland Park, KS 66210. Our interactive voice response (IVR) system is also available 24 hours a day, 7 days a week.

Please provide the following information when submitting a State Fair Hearing request:

- Your name, address, phone number, email and either your NPI or TIN
- The member's name and their Amerigroup or Medicaid ID number
- The specific reason for the hearing, to include the:
  - Claim number and the date(s) of service(s), or;
  - Denied service and the date of the notice of appeal; and
  - The Amerigroup appeal number

Amerigroup will mail you an acknowledgement of your request.

### **Claims Related to Medical Necessity**

For claims payment issues related to denial on the basis of medical necessity, we contract with physicians who are not network providers to resolve claims appeals that remain unresolved subsequent to a determination.

Amerigroup will abide by the determination of the physician resolving the dispute. You are expected to do the same. We will ensure the physician resolving the dispute will hold the same specialty or a related specialty as the appealing provider.

A licensed/registered nurse will review payment appeals received with supporting clinical documentation when medical necessity review is required. We will apply established clinical criteria to the payment appeal. After review, we will either approve the payment dispute or forward it to the medical director for further review and resolution.

## 4. PROGRAM OVERVIEW, BENEFITS AND LIMITATIONS

### 4.1 KanCare Programs Description

KanCare is Medicaid and Children's Health Insurance Program (CHIP) managed care that integrates physical health, behavioral health and pharmacy services with certain long-term services and supports for those qualifying for certain waivers, nursing facility care and private intermediate care facility for people with intellectual or developmental disabilities (ICF/IDD) services. It covers the following populations:

- Temporary Assistance for Needy Families (TANF)
- Pregnant women
- Newborns
- Those receiving Supplemental Security Income (SSI)
- Those dually eligible for Medicare and Medicaid
- Those meeting the criteria for ICF/IDD or nursing facilities
- Those participating in Medicaid via the Spend Down program
- Those participating in waivers, including:
  - Technology Assisted Waiver
  - Autism Waiver
  - Serious Emotional Disturbance (SED) Waiver
  - Physical Disability Waiver
  - Frail Elderly Waiver
  - Traumatic Brain Injury Waiver
  - Intellectual/Developmental Disability (I/DD) Waiver

Amerigroup is one of the participating MCOs providing services to KanCare members statewide.

### 4.2 Covered Benefits through Amerigroup

So that you, as a provider, see the benefit information our members see, the covered services chart below closely mirrors the information found in our member handbook.

We do not cover experimental procedures or medications unless specifically noted in the chart below.

Amerigroup maintains a benefit package and procedural coverage for members at least as comprehensive as the Medicaid State plan.

COVERED SERVICES	SERVICE DESCRIPTION	COVERAGE LIMITS
<b>MEDICAL SERVICES</b>		
<b>ANESTHESIA</b>	The loss of feeling or sensation, that is, partial or complete sensory paralysis, commonly induced artificially with drugs or gases for the period of a surgical operation. Anesthesia may be either general, wherein the patient is rendered unconscious, or local where a localized area is rendered insensate.	General anesthesia is covered for: <ul style="list-style-type: none"><li>• Radiological procedures for children and/or</li><li>• Patients, when the medically needed procedure cannot be performed unless the patient is given anesthesia</li><li>• Modifier QY is non-covered</li></ul>

COVERED SERVICES	SERVICE DESCRIPTION	COVERAGE LIMITS
<b>ASSISTIVE/ AUGMENTATIVE COMMUNICATION DEVICES</b>	<ul style="list-style-type: none"> <li>Assistive/augmentative communication devices involve aids or techniques that supplement severely limited vocal or verbal communication skills. Examples of augmentative and alternative communication are speech synthesizers and other mechanical and electronic devices. These devices give severely speech-impaired people ways to communicate their thoughts with others.</li> <li>Interpretive services, also known as a telephone device for the deaf, allows the hearing impaired to use a typewriter-like device to communicate and send messages over the phone to a relay service for translation by an interpreter. This service also includes translation services.</li> </ul>	<p>Assistive/augmentative communication devices include aids or techniques that help improve severely limited vocal or verbal communication skills; examples include:</p> <ul style="list-style-type: none"> <li>Speech synthesizers</li> <li>Other mechanical and electronic devices</li> </ul> <p>These devices give those who are severely speech-impaired ways to convey their thoughts to others.</p> <p>Interpretive services, also known as a telephone device for the deaf (TDD), lets those who are deaf or hard of hearing:</p> <ul style="list-style-type: none"> <li>Use a typewriter-like device to communicate and send messages over the phone to a relay service for translation by an interpreter</li> <li>Access translation services</li> </ul> <p>Certain limits apply. Precertification required. Precertification requirement is based on the CPT/HCPCS code and can be found in our online precertification look up tool.</p> <p>See the section <b>Medical Services for Members in Waiver Groups</b> for services covered.</p>
<b>AUDIOLOGY SERVICES</b>	<ul style="list-style-type: none"> <li>Audiology is the branch of science that studies hearing, balance and their disorders. Its practitioners, who study hearing and treat those with hearing losses, are audiologists. Employing various testing strategies (e.g., hearing tests, otoacoustic emission measurements and electrophysiological tests), audiology aims to determine whether someone can hear within the normal range, and if not, which portions of hearing (high, middle or low frequencies) are affected and to what degree. If an audiologist diagnoses a hearing loss, he or she will provide recommendations to a patient as to what options (e.g., hearing aids, cochlear implants, surgery, appropriate medical referrals) may be of assistance.</li> <li>A hearing aid is an apparatus/electronic device that amplifies sound for persons with impaired hearing. The device consists of a microphone, a battery power supply, an amplifier and a receiver.</li> </ul>	<p>Covered services include:</p> <ul style="list-style-type: none"> <li>Hearing aid repairs</li> <li>Fitting of monaural hearing aids</li> <li>Fitting of binaural hearing aids, with documentation on the hearing evaluation form, for: <ul style="list-style-type: none"> <li>Children under 21 years of age (Medicaid or CHIP)</li> <li>A legally blind adult with significant bilateral hearing loss</li> <li>A previous binaural hearing aid user or</li> <li>An occupational requirement for binaural listening</li> </ul> </li> <li>A bone anchored hearing aid (BAHA) when certain medical conditions are met for members who: <ul style="list-style-type: none"> <li>Are age 5 or older</li> <li>Cannot use standard hearing aids due to a medical condition</li> <li>Have the manual dexterity or the help needed to snap the device onto the abutment</li> <li>Can maintain proper hygiene where the fixture is kept</li> </ul> </li> </ul> <p>Certain limits apply. Precertification required. Use our online precertification look-up tool or</p>

COVERED SERVICES	SERVICE DESCRIPTION	COVERAGE LIMITS
		call our Provider Services team.
<b>BEHAVIORAL HEALTH – MENTAL HEALTH SERVICES</b>		<p>Covered mental health services are listed below. Not all services are covered for all members. Call Provider Services at 1-800-454-3730 to check benefits. For information on notification and precertification requirements, please see Appendix B.</p> <p>Covered services include:</p> <ul style="list-style-type: none"> <li>• Inpatient admission, evaluation and assessment</li> <li>• Inpatient psychiatric treatment – requires an inpatient psychiatric hospital pre-admission screening</li> <li>• 23-hour observation</li> <li>• Electro-convulsive treatment (ECT)</li> <li>• Treatment in a mental health nursing facility for members under age 21 or over age 65.</li> <li>• Psychological and neuropsychological testing</li> <li>• Assessments for members who may be seriously and persistently mentally ill (SPMI) or may have a serious emotional disturbance (SED)</li> <li>• Targeted case management (except for CHIP population)</li> <li>• Treatment planning with members and members' families</li> <li>• Crisis response and intervention</li> <li>• Outpatient therapy and medication management, including: <ul style="list-style-type: none"> <li>– Evaluation and assessment</li> <li>– Individual, family and group therapy</li> <li>– Medication management and administration</li> <li>– Case consults</li> </ul> </li> <li>• Psychosocial Rehabilitation Community Psychiatric Support and Treatment</li> <li>• Peer Support Attendant care (1915b)</li> <li>• Case Conference</li> <li>• Crisis Intervention</li> <li>• KAN Be Healthy services, including: <ul style="list-style-type: none"> <li>– Evaluation and assessment</li> <li>– Service plan development</li> </ul> </li> </ul> <p>See the section <b>Medical Services for Members in Waiver Groups</b> for services covered for waiver-enrolled members.</p> <p>The following services require precertification:</p>



COVERED SERVICES	SERVICE DESCRIPTION	COVERAGE LIMITS
		<ul style="list-style-type: none"> <li>Inpatient psychiatric treatment</li> </ul> <p>Other services require prior notification as well as authorization and medical necessity review after specified limits are reached. Traditional outpatient therapy services do not require precertification. Call our Provider Services team for help understanding precertification requirements for any service or use our online precertification look-up tool.</p>
<b>BEHAVIORAL HEALTH – PSYCHIATRIC RESIDENTIAL TREATMENT FACILITY (PRTF)</b>		Treatment in a Psychiatric Residential Treatment Facility (PRTF) is a covered service.
<b>BEHAVIORAL HEALTH – SUBSTANCE USE DISORDERS</b>		<p>Inpatient Substance Use Disorder services</p> <p>For information on precertification requirements, please see Appendix B. Substance use disorder services indicated below will be provided upon member self-referral and will be reviewed for medical necessity after a predetermined number of hours or days. These services must be requested in the Kansas Client Placement Criteria (KCPC) system.</p> <p><b>Level I</b> Covered outpatient treatment, including:</p> <ul style="list-style-type: none"> <li>Individual counseling</li> <li>Group counseling</li> </ul> <p><b>Level II</b> Covered services include:</p> <ul style="list-style-type: none"> <li>Intensive outpatient services</li> <li>Partial hospitalization</li> </ul> <p><b>Level III</b> Covered residential/inpatient services, including:</p> <ul style="list-style-type: none"> <li>Reintegration care</li> <li>Intermediate care</li> <li>Acute detoxification treatment</li> </ul> <p><b>Auxiliary Services</b> Covered services include:</p> <ul style="list-style-type: none"> <li>Assessment and referrals</li> <li>Medicaid case management</li> <li>Peer support</li> <li>Crisis intervention</li> </ul> <p><b>Court-ordered/Civil Commitment Services, as medically needed</b> Screening, Brief Intervention and Referrals For Treatment (SBIRT) services are also covered. Providers must meet state provider type, location and training requirements.</p>

COVERED SERVICES	SERVICE DESCRIPTION	COVERAGE LIMITS
<b>BLOOD ADMINISTRATION AND OTHER BLOOD PRODUCTS</b>	Blood administration involves the introduction of blood or blood plasma into a vein or artery.	<p>Covered services include:</p> <ul style="list-style-type: none"> <li>• Blood transfusions, including transfusions from the same person, ordered by a qualified network provider</li> <li>• Blood transfusions, including whole blood, red blood cells, plasma and IV infusions</li> <li>• Blood products administered less than four hours, intermittently, weekly or monthly as part of Intermittent Intensive Medical Care (IIMC) for members in the Technology Assisted (TA) waiver group</li> </ul>
<b>CARE COORDINATION</b>		<p>Case management is designed to respond to a member's needs when the member's condition or diagnoses require care and treatment for long periods of time.</p> <p>Service coordination is designed to give support and respond to the needs of persons who have long-lasting limits caused by:</p> <ul style="list-style-type: none"> <li>• An illness</li> <li>• An injury or</li> <li>• A disability</li> </ul> <p>Our service coordinators work mainly with:</p> <ul style="list-style-type: none"> <li>• Waiver participants and</li> <li>• Those living in a nursing facility or an ICF/IDD</li> </ul> <p>When a member is in a case management program:</p> <ul style="list-style-type: none"> <li>• An Amerigroup nurse helps identify other medically suited methods or settings in which care may be given</li> <li>• A provider, on behalf of the member, may request to take part in the program; the nurse will work with the member and the member's providers to decide: <ul style="list-style-type: none"> <li>– The level and types of services needed</li> <li>– Other settings where care may be given</li> <li>– Equipment and/or supplies needed</li> <li>– Community-based services nearby</li> <li>– Communication needed between the member and the member's Primary Care Provider (PCP) and specialists</li> </ul> </li> </ul> <p>When a member is being served by a service coordinator, he or she works with the member and family to:</p> <ul style="list-style-type: none"> <li>• Assess the services and benefits needed to promote independence and</li> <li>• Help the member stay in the community</li> </ul>

COVERED SERVICES	SERVICE DESCRIPTION	COVERAGE LIMITS
		<p>setting</p> <p><b>Complete Member Assessment</b></p> <p>A case manager or service coordinator will assess a member's health care needs. This assessment includes:</p> <ul style="list-style-type: none"> <li>• A range of questions to identify and assess the member's: <ul style="list-style-type: none"> <li>– Medical/mental health and social needs</li> <li>– Functional limits</li> <li>– Ability for self-care</li> <li>– Current treatment plan</li> </ul> </li> <li>• Phone interviews or home visits to collect and assess information received from members or their representatives; to complete the assessment, case managers will also get information from: <ul style="list-style-type: none"> <li>– The member's PCP and specialists</li> <li>– Other sources to set up and decide the member's current medical and nonmedical service needs</li> </ul> </li> </ul> <p><b>Individualized Plan of Care</b></p> <p>Case managers and service coordinators will use information from the assessment to set up a member-centered plan of care. They will:</p> <ul style="list-style-type: none"> <li>• Work with the member, his or her family, and the member's providers to develop and set up the proper care plan</li> <li>• Think of the member's needs for social, educational, therapeutic and other nonmedical support services, as well as the strengths and needs of the family</li> <li>• Teach the member about self-direction opportunities and waiver services as fitting</li> <li>• Teach and assist members in institutions who want to return to the community how to do so</li> <li>• Set up a service plan that promotes the highest level of independence possible</li> </ul> <p>They will work with the member's PCP and specialists to ensure the plans of care support the providers' medical plans.</p> <p>Covered services include:</p> <ul style="list-style-type: none"> <li>• Services to assess, plan, arrange and monitor the options to meet a person's health care needs</li> </ul>
<b>CARDIAC REHAB SERVICES</b>	Cardiac Rehabilitation is a program recommended for patients who have had a heart attack, angina, congestive heart failure or other forms of heart disease or those who have undergone heart surgery. A cardiac	<p>Covered services include:</p> <ul style="list-style-type: none"> <li>• <b>Phase II Cardiac Rehab</b> when performed in an outpatient or cardiac rehab unit setting and when the member:</li> </ul>

COVERED SERVICES	SERVICE DESCRIPTION	COVERAGE LIMITS
	rehabilitation program includes counseling and information about the patient's condition; a supervised exercise program; lifestyle and risk factor modification programs such as smoking cessation, information on nutrition and controlling high blood pressure; and emotional and social support.	<ul style="list-style-type: none"> <li>Has completed a recent cardiology consult within three months of starting the cardiac rehab program</li> <li>Has completed <b>Phase I Cardiac Rehab</b> and</li> <li>Has had one or more of the following conditions: <ul style="list-style-type: none"> <li>Acute heart attack within the last three months after an inpatient discharge</li> <li>Coronary bypass surgery within three months after an inpatient discharge</li> <li>Stable angina pectoris (<i>chest pain, usually caused by lack of oxygen to the heart muscle</i>) within three months after diagnosis</li> </ul> </li> <li><b>Patient Demand Cardiac Monitoring</b>, under certain conditions</li> </ul> <p>Certain limits apply. Precertification is required.</p>
<b>CHEMOTHERAPY/ RADIATION</b>	<ul style="list-style-type: none"> <li>Chemotherapy is the use of drugs to kill bacteria, viruses, fungi and most commonly cancer cells.</li> <li>A chemotherapy regimen (a treatment plan and schedule) usually includes drugs to fight cancer plus drugs to help support completion of the cancer treatment at the full dose on schedule.</li> <li>Radiation therapy is the use of a certain type of energy (called ionizing radiation) to kill cancer cells and shrink tumors.</li> </ul> <p>In some cases, the goal of radiation treatment is to completely destroy an entire tumor; in other cases, the aim is to shrink a tumor and relieve symptoms; in either case, doctors plan treatment to spare as much healthy tissue as possible.</p>	<p>Covered services include:</p> <ul style="list-style-type: none"> <li>Life sustaining therapies as ordered by a qualified health provider, such as <ul style="list-style-type: none"> <li>Chemotherapy and</li> <li>Radiation</li> </ul> </li> </ul> <p>See the section <b>Medical Services for Members in Waiver Groups</b> for services covered for members in the Technology Assisted (TA) waiver group.</p> <p>Precertification is required.</p>
<b>CHIROPRACTIC SERVICES</b>	A health profession concerned with the diagnosis, treatment and prevention of mechanical disorders of the musculoskeletal system, and the effects of these disorders on the function of the nervous system and general health. There is an emphasis on manual treatments including spinal manipulation or adjustment.	Only crossover services from Medicare are covered for dual-eligible members. Medicare limits apply. Chiropractic services are not covered for Medicaid members.
<b>CIRCUMCISIONS</b>	Circumcision is the surgical removal of the end of the prepuce of the penis for males of all ages. Circumcision is usually performed at the request of the parents or physician. There are very few medical indications for this procedure.	Certain limits apply. Circumcisions are covered. No precertification required.

COVERED SERVICES	SERVICE DESCRIPTION	COVERAGE LIMITS
<b>CLINICAL TRIALS</b>	A carefully designed and executed investigation of the effects of a drug administered to human subjects. The goal is to define the clinical effectiveness and pharmacological effects (toxicity, side effects, incompatibilities or interactions) of the substance.	Covered when medically necessary. Precertification may be required.
<b>COCHLEAR IMPLANTS</b>	A cochlear implant device is an electronic instrument, part of which is implanted surgically to stimulate auditory nerve fibers, and part of which is worn or carried by the individual to capture, analyze and code sound. The purpose of implanting the device is to provide awareness and identification of sounds and to facilitate communication for persons who are profoundly hearing impaired.	<p>Covered services include:</p> <p><b>Medicaid members under age 21 and CHIP members under age 19</b></p> <ul style="list-style-type: none"> <li>• Cochlear implants</li> <li>• Devices</li> <li>• Accessories</li> <li>• Repairs</li> <li>• Batteries</li> <li>• Replacement cords for cochlear implants when medically needed</li> </ul> <p>Certain coverage limits apply:</p> <p><b>Medicaid members under age 21 and CHIP members under age 19</b></p> <ul style="list-style-type: none"> <li>• Headset/headpiece, microphone and transmitting coils may be replaced once a year</li> <li>• Cochlear external speech processor replacements are covered one time in a four-year period if current processor: <ul style="list-style-type: none"> <li>– Is not working, cannot be repaired and is no longer under warranty or</li> <li>– Is lost</li> </ul> </li> <li>• Certain types of batteries may be replaced every 30 days</li> </ul> <p>Precertification may be required. Use our online precertification look-up tool to search requirements by HCPCS/CPT code.</p>
<b>COURT-ORDERED SERVICES</b>	<p>Court-ordered services are those mandated by:</p> <ul style="list-style-type: none"> <li>• A court of law or</li> <li>• Other enforcement agency</li> </ul>	<p>Covered services include those services:</p> <ul style="list-style-type: none"> <li>• Ordered by a court of law or other enforcement agency</li> </ul> <p>This includes medically necessary services.</p>
<b>COSMETIC/PLASTICS/RECONSTRUCTIVE PROCEDURES</b>	Reconstructive surgery is performed on abnormal structures of the body, caused by birth defects, developmental abnormalities, trauma or injury, infection, tumors or disease. It is generally performed to improve function, but may also be done to approximate a normal appearance. This may include but not limited to: cleft palate repair, breast reconstruction, etc. This differs from cosmetic surgery which is performed to reshape normal structures of the body to improve the patient's appearance and self-esteem. This may	<p>Covered services include the surgery and related services and supplies to:</p> <ul style="list-style-type: none"> <li>• Correct physical defects from birth, an illness or physical trauma or</li> <li>• Perform mastectomy reconstruction for post-cancer treatment</li> <li>• Reconstruction is limited to one process per breast per lifetime.</li> </ul> <p>Precertification is required.</p>

COVERED SERVICES	SERVICE DESCRIPTION	COVERAGE LIMITS
	include but not limited to: Blepharoplasty, Botox, Breast Augmentation, etc.	
<b>DENTAL CARE</b>	<ul style="list-style-type: none"> <li>Dental (Accident/Injury Only) — dental services associated with the structure of the oral cavity and contiguous tissues due to injury, or impairment which may affect the oral or general health of the individual.</li> <li>Dental (Preventive, Restorative) — any diagnostic, preventive, or corrective dental procedures administered by or under the direct personal supervision of a dentist in the practice of the practitioner's profession.</li> <li>Dental (Orthodontics) — a specialty of dentistry concerned with the study and treatment of malocclusions (improper bites), which may be a result of tooth irregularity, disproportionate jaw relationships, or both.</li> </ul>	<p>Covered services include:</p> <p>For members age 20 and younger:</p> <ul style="list-style-type: none"> <li>Exam and cleaning every six months</li> <li>X-rays when required for proper treatment and diagnosis</li> <li>Fillings, tooth restoration, extractions and other treatments for children who qualify</li> <li>Topical application of fluoride of three treatments per member per calendar year when billed by a professional provider and three treatments per 12 months for the same member when billed by a dental provider.</li> </ul> <p>For Medicaid members age 21 and older:</p> <ul style="list-style-type: none"> <li>Extractions when medically needed</li> <li>Exams and X-rays when used to decide if an extraction is medically needed</li> </ul> <p>Members also get this extra benefit:</p> <ul style="list-style-type: none"> <li>Two cleanings per year, scaling and polishing</li> </ul> <p>For ICF/IDD members age 21 and above:</p> <ul style="list-style-type: none"> <li>Exam and cleaning every six months</li> <li>X-rays when required for proper treatment and diagnosis</li> <li>Fillings, tooth restoration, extractions and other treatments for members who qualify</li> </ul> <p>For MFP Frail Elderly members:</p> <ul style="list-style-type: none"> <li>Exam and cleaning every six months</li> <li>X-rays when required for proper treatment and diagnosis</li> <li>Fillings, tooth restoration, extractions and other treatments for members who qualify</li> </ul> <p>Dentures and related procedures:</p> <p>Frail Elderly Waiver Members</p> <p>Members in the Frail Elderly waiver may be eligible for oral health services that are not</p>

COVERED SERVICES	SERVICE DESCRIPTION	COVERAGE LIMITS
		<p>otherwise covered for Medicaid adults. These services are limited to crisis exception scenarios according to the member's assessed level of service need as specified in the member's plan of care. These are accepted dental procedures that can include diagnostic, prophylactic and restorative care, as well as anesthesia services provided in the dentist's office. Crisis exception scenarios may also allow for the purchase, adjustment and repair of dentures.</p> <p>Note: Dental providers can access the Scion Dental provider manual on our provider website for a full list of covered services and codes.</p>
<b>DIABETES SERVICES</b>	<ul style="list-style-type: none"> <li>• Diabetic screening: laboratory testing of members with certain risk factors for diabetes or diagnosed with pre-diabetes.</li> <li>• Diabetic self-management training: a program intended to educate members in the successful self-management of diabetes. The program includes instructions in self-monitoring of blood glucose; education about diet and exercise; an insulin treatment plan developed specifically for the patient who is insulin-dependent; and motivation for patients to use the skills for self-management.</li> <li>• Diabetic supplies: items necessary for the self-testing of glucose levels of the blood for the purposes of monitoring and control of diabetes. These may include but are not limited to syringes, lancets, needles, etc.</li> </ul>	<p>Covered services include home health services that:</p> <ul style="list-style-type: none"> <li>• Help eligible members manage their diabetes in a home setting instead of a nursing facility or other institution</li> <li>• Are reasonable and medically needed</li> <li>• Do not duplicate other resources offered</li> <li>• Diabetic supplies – refer to Medical Supplies section for details</li> </ul>
<b>DIAGNOSTIC TESTING (LABORATORY AND RADIOLOGY/NUCLEAR MEDICINE)</b>	<ul style="list-style-type: none"> <li>• Laboratory and radiology: testing or clinical studies of materials, fluids or tissues from patients. <ul style="list-style-type: none"> <li>– Services include but are not limited to the obtaining and testing of blood samples, histology, hematology, blood chemistry, pathology, histopathology, microbiology and other diagnostic testing using physical specimens such as tissue, sputum, feces, urine or blood.</li> <li>– Services may include but not limited to Bone Mass/Density Study-Bone Biopsy/Photon, HIV/AIDS Testing, Lead Blood Screening, Prostate-Specific Antigen (PSA) testing, Thermography/Thermograms,</li> </ul> </li> </ul>	<p><b>Lab and radiology</b> Covered services include:</p> <ul style="list-style-type: none"> <li>• Obtaining and testing of blood samples, hematology, blood chemistry, microbiology and other diagnostic testing, using physical specimens such as tissue, urine or blood</li> </ul> <p><b>Nuclear medicine</b></p> <ul style="list-style-type: none"> <li>• Procedures and tests performed by a radioisotope lab, using radioisotope materials as required for diagnosis and treatment of patients (e.g., MRI, MRA and cardiac care)</li> <li>• Restrictions: <ul style="list-style-type: none"> <li>– Cytogenetic (chromosome) studies are covered for pregnant women (when</li> </ul> </li> </ul>

COVERED SERVICES	SERVICE DESCRIPTION	COVERAGE LIMITS
	<p>Sleep Studies and Sleep Therapy, Portable X-Ray services, Preadmission tests, Radiology, and Colorectal Cancer Screening procedures, including Barium enemas, Sigmoidoscopy, Fecal Occult Blood Tests (FOBT) and Screening Colonoscopy.</p> <ul style="list-style-type: none"> <li>• Nuclear medicine: procedures and tests performed by a radioisotope laboratory utilizing radioactive materials as required for diagnosis and treatment of patients. Examples may include but are not limited to CT scan, MRI, MRA and cardiology.</li> </ul>	<p>medically necessary) and for Medicaid members under age 21 and CHIP members under age 19. A medical necessity form must accompany the claim when billing for a cytogenetic study for a pregnant woman older than 21 years of age.</p> <ul style="list-style-type: none"> <li>• Refer to benefit type WTAS for lab draw coverage information for members in the HCBS Technology Assisted (TA) Waiver.</li> <li>• Laboratory services performed by the Kansas Department of Health and Environment are excluded from the Amerigroup contract with Kansas but may be covered by fee-for-service for Medicaid-eligible persons.</li> <li>• Preoperative and routine admission chest X-rays will not be covered unless documentation of medical necessity (one or more of the following factors) is noted on the claim: <ul style="list-style-type: none"> <li>– 60 years of age or older;</li> <li>– Pre-existing or suspected cardiopulmonary disease;</li> <li>– Smokers over age forty; or,</li> <li>– Acute medical/surgical conditions such as malignancy or trauma.</li> </ul> </li> <li>• A routine obstetrical (OB) sonogram will not be covered if the sonogram is performed solely to determine the fetal sex or to provide parents a view and photograph of the fetus.</li> <li>• Claims for UGI X-rays are denied reimbursement when the diagnosis code on the claim is either too nonspecific or is the result, rather than the reason, for the procedure. (See Additional Information.)</li> <li>• Handling fee (drawing/collection) is considered content of service of the outpatient visit/lab procedure and is not covered if billed separately.</li> <li>• Laboratory procedures performed on inpatients are content of service of the DRG reimbursement to the hospital and should not be billed by either the independent laboratory or hospital.</li> <li>• Urinalysis (UA) is considered content of service of the reimbursement to the physician for antepartum care when the UA is obtained for a diagnosis of pregnancy. The hospital/independent laboratory will not be reimbursed by Medicaid for the UA in this situation.</li> </ul>



COVERED SERVICES	SERVICE DESCRIPTION	COVERAGE LIMITS
		<ul style="list-style-type: none"> <li>• Infertility services, including any tests, procedures, or drugs related to infertility services, are not covered.</li> <li>• For all hospitals except critical access hospitals, outpatient procedures (including, but not limited to, surgery, X-rays and EKGs) provided within three days of a hospital admission for the same or similar diagnosis are considered content of services. Complications from an outpatient sterilization resulting in an inpatient admission are the only exception to this policy.</li> </ul> <p>Precertification may be required.</p>
<b>DIALYSIS (END STAGE RENAL DISEASE)</b>	<p>Dialysis services are those provided for the artificial and mechanical removal of toxic materials and the maintenance of fluid, electrolyte, and acid-base balances in cases of impaired or absent kidney function. A freestanding clinic is a facility that operates solely for the provision of dialysis services. These services also include home dialysis services that are patient/patient's representative managed under the supervision of the clinic. For locations other than freestanding, the services are rendered either in an inpatient or outpatient hospital setting.</p>	<p>Covered services for persons with End Stage Renal Disease (ESRD) or acute renal failure include:</p> <ul style="list-style-type: none"> <li>• Life-sustaining therapies, including renal dialysis as ordered by a qualified network provider</li> <li>• Treatment for conditions directly related to ESRD until the member is eligible for Medicare</li> <li>• Training and supervision of personnel and clients for home dialysis, medical care and treatment, including home dialysis helpers</li> <li>• Supplies and equipment for home dialysis</li> <li>• Diagnostic lab work</li> <li>• Treatment for anemia and</li> <li>• Intravenous drugs</li> </ul> <p>Precertification is required.</p> <p>See the section <b>Medical Services for Members in Waiver Groups</b> for services covered for members in the Technology Assisted (TA) waiver group.</p>
<b>DRUGS/INJECTABLES/ PHARMACEUTICALS</b>		<p>Covered services include:</p> <ul style="list-style-type: none"> <li>• All home health/home infusion services (including drugs dispensed)</li> </ul> <p>Prescription drug products, according to the approved drug formulary. Amerigroup uses the state formulary and preferred drug list. Some therapeutic classes not listed on the PDL will continue to be covered as they always have for the Kansas Medical Assistance Pharmacy Program.</p> <ul style="list-style-type: none"> <li>• Medically needed nutritional supplements for infants</li> <li>• Legend prenatal vitamins for members who are pregnant; includes up to three months postpartum coverage for women who are breastfeeding</li> </ul>

COVERED SERVICES	SERVICE DESCRIPTION	COVERAGE LIMITS
		<ul style="list-style-type: none"> <li>• Prescription weight loss drugs, smoking cessation products and benzodiazepines when medically needed</li> <li>• Medically needed over-the-counter products with a prescription, including diabetic supplies, glucometers and blood glucose strips</li> <li>• Precertification may be required if permitted by Kansas policy</li> </ul>
<b>DURABLE MEDICAL EQUIPMENT</b>	<p>Durable Medical Equipment (DME) is primarily and customarily used to serve a medical purpose, is appropriate for use in the home, and can withstand repeated use. Includes: Adaptive Equipment/Aids, Humidifiers, Oxygen and Related Respiratory Equipment, Nebulizers, and Glucometers. DME does not include disposable medical supplies.</p>	<p>Covered services include medically needed DME, appliances and assistive devices, which include but are not limited to:</p> <ul style="list-style-type: none"> <li>• Adaptive equipment/hearing aids</li> <li>• Humidifiers</li> <li>• Oxygen and related respiratory equipment</li> <li>• Nebulizers</li> <li>• Glucometers</li> </ul> <p>Certain limits apply. Precertification is required for most DME.</p> <p>Waiver members will have access to an added list of DME based on the waiver.</p>
<b>EDUCATIONAL COUNSELING AND HEALTH PROMOTION</b>	<p>Teaching and training services (also referred to as educational services) provide knowledge essential to the member's condition and participation in his or her own treatment. Nutritional Assessment, Risk Reduction, and Education are a preventive primary service and must be furnished by or under the direct supervision of a physician, nurse practitioner, physician assistant, certified nurse midwife, clinical psychologist, or a clinical social worker. Health promotion is the science and art of helping people change their lifestyle to move toward a state of optimal health. Lifestyle change can be facilitated through a combination of efforts to enhance awareness, change behavior and create environments that support good health practices.</p>	<p>Covered services include:</p> <ul style="list-style-type: none"> <li>• Health education for heart disease</li> <li>• Medical nutrition therapy provided by a certified dietician for members age 20 and younger who are in an eligible program, when referred by an EPSDT provider</li> </ul>

COVERED SERVICES	SERVICE DESCRIPTION	COVERAGE LIMITS
<b>EARLY CHILDHOOD INTERVENTION (ECI) AND SCHOOL-BASED SERVICES</b>	<p>Program for families with children ranging from birth to school age with developmental disabilities and delays, the program provides screening and resource referral processes that support families in helping the effected children reach their potential through developmental services.</p>	<p>While services provided in schools by Early Childhood Intervention providers and Local Education Agencies are not covered by Amerigroup but are reimbursed by the state, Amerigroup covers:</p> <ul style="list-style-type: none"> <li>• School-based services provided by local health departments</li> <li>• Covered services provided in schools by community mental health centers</li> <li>• Covered services in situations where a child's course of treatment is interrupted due to school breaks, after school hours or during summer months</li> </ul> <p>Amerigroup is responsible for coordinating services between the ECI program and Amerigroup covered services.</p>
<b>KAN BE HEALTHY</b>	<p>Early Periodic Screening, Diagnosis and Treatment (EPSDT) programs cover screening and diagnostic services to determine physical or mental defects in recipients under age 21, as well as health care and other measures to correct or improve any defects and chronic conditions discovered.</p> <p>Well-baby and well-child care services include regular or preventive diagnostic and treatment services necessary to ensure the health of babies, children and adolescents as defined by the state.</p> <p>The KAN Be Healthy program utilizes the resources of the American Academy of Pediatrics (AAP) Bright Futures Website: <a href="http://brightfutures.aap.org/Pages/default.aspx">brightfutures.aap.org/Pages/default.aspx</a>.</p> <p>Amerigroup informs KAN Be Healthy eligible members and/or parents of the availability of services and the need for age-appropriate immunizations through various forms of outreach.</p>	<p>Covered services include:</p> <ul style="list-style-type: none"> <li>• Complete medical screens, including: <ul style="list-style-type: none"> <li>– Complete health and development history with assessment for both physical and mental health development</li> <li>– Complete, unclothed physical exam</li> <li>– Proper immunizations (shots) according to Advisory Committee on Immunization Practices (ACIP); immunizations must be reviewed at each screen and brought up-to-date as necessary and according to age and health history</li> <li>– Lab tests, including lead blood level assessment</li> <li>– Health education</li> <li>– Vision screening</li> <li>– Hearing screening</li> <li>– Dental screenings</li> </ul> </li> <li>• Other needed health care or diagnostic screens or exams</li> </ul> <p>Certain limits apply.</p> <p>Noncovered services may be covered for members eligible for KAN Be Healthy (Medicaid children under age 21 and CHIP children under age 19) if the services are medically necessary to treat, correct or reduce illnesses and conditions. Precertification must be obtained from Amerigroup in these cases.</p>

COVERED SERVICES	SERVICE DESCRIPTION	COVERAGE LIMITS
<b>EMERGENCY MEDICAL SERVICES</b>	<p>An emergency medical condition is a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, with an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in: serious jeopardy to the health of the individual or, in the case of a pregnant woman, the health of the woman or her unborn child; serious impairment to bodily functions; or serious dysfunction of any bodily organ or part.</p> <p>Emergency services are inpatient and outpatient services that are furnished by a provider qualified to furnish emergency services and that are needed to evaluate or stabilize an emergency medical condition; may include Behavioral Health Emergency Room Services.</p>	<p>Covered services include emergency services given by a network or out-of-network provider under these conditions:</p> <ul style="list-style-type: none"> <li>• The member has an emergency medical condition; this includes cases in which the absence of getting medical care right away would not have had the outcome defined as an emergency medical condition or</li> <li>• Amerigroup tells the member to get emergency services</li> </ul> <p>The attending emergency physician or the provider treating the member will decide when he or she is stable for transfer or discharge.</p> <p>Precertification is not required.</p>
<b>ENTERAL NUTRITION</b>	<p>Enteral nutrition, also called tube feeding, is a way to provide food through a tube placed in the nose, the stomach or the small intestine.</p>	<p>Covered services include:</p> <ul style="list-style-type: none"> <li>• DME, home health, home infusion and medical supply services provided in the home</li> <li>• Medically needed tube-fed products and supplies for eligible adults</li> <li>• Medically needed oral and tube-fed enteral nutrition for eligible children age 20 and younger</li> <li>• Repairs and replacement parts for tube-delivered enteral nutrition equipment when <ul style="list-style-type: none"> <li>– Owned by the patient</li> <li>– The equipment is less than five years old and no longer under warranty</li> </ul> </li> </ul> <p>Certain limits apply. Precertification is required. These members may have access to added benefits:</p> <ul style="list-style-type: none"> <li>• Technology Assisted waiver participants</li> <li>• Hospice and nursing facility residents</li> </ul>
<b>FAMILY PLANNING SERVICES</b>	<p>Family planning services include counseling, information, education and communication activities, and delivery of contraceptives/ birth control.</p>	<p>Family planning services are covered for members of childbearing age who choose to delay or prevent pregnancy. Services include:</p> <ul style="list-style-type: none"> <li>• Medical history and physical exam</li> <li>• Annual physical assessment; nonprescribed methods can be seen every two years</li> <li>• Lab tests performed as part of an initial or regular follow-up visit or exam for the purpose of family planning: <ul style="list-style-type: none"> <li>– Pap smears</li> <li>– Gonorrhea and chlamydia testing</li> <li>– Syphilis serology</li> <li>– HIV testing</li> </ul> </li> </ul>

COVERED SERVICES	SERVICE DESCRIPTION	COVERAGE LIMITS
		<ul style="list-style-type: none"> <li>– Rubella titer</li> <li>• Education               <ul style="list-style-type: none"> <li>– Reproductive anatomy and physiology</li> <li>– Fertility regulation</li> <li>– STD transmission</li> </ul> </li> <li>• Counseling to help make an informed decision</li> <li>• Method counseling — to give results of history and physical exam, means of action, and the side effects and possible complications</li> <li>• Special counseling (when stated) — pregnancy planning and management, sterilization, genetics and nutrition</li> <li>• Pregnancy diagnosis, counseling and referral</li> <li>• Oral contraceptives and other contraceptive methods, including but not limited to insertion of Norplants, IUD and Depo-Provera injections</li> </ul> <p>Members do not need a referral for family planning services. Members may choose a network or non-network provider.</p>
<b>GASTRIC BYPASS/OBESITY SURGERY/BARIATRICS</b>	<ul style="list-style-type: none"> <li>• Bariatrics is a branch of medicine focusing on prevention and control of obesity.</li> <li>• Gastric bypass/obesity surgery is the treatment of obesity.</li> </ul>	<p>Covered services for qualifying members may include:</p> <ul style="list-style-type: none"> <li>• Surgeries on the stomach and/or intestines to help a person with extreme obesity lose weight               <ul style="list-style-type: none"> <li>– Bariatric surgery is a weight-loss method used for those who have a body mass index (BMI) above 40.</li> <li>– Surgery may also be an option for those with a BMI between 35 and 40 who have health problems like heart disease or Type II diabetes.</li> <li>– Bariatric surgery is covered only when performed at a Center of Excellence.</li> <li>– Bariatric surgery is not covered as a treatment for infertility.</li> <li>– The following procedures/services are considered experimental and investigational and are not covered:                   <ul style="list-style-type: none"> <li>▪ Bariatric surgery as a treatment for idiopathic intracranial hypertension</li> <li>▪ Gastroplasty, more commonly known as “stomach stapling”</li> <li>▪ Intragastric balloon</li> <li>▪ Laparoscopic gastric plication</li> <li>▪ LASGB, RYGB and BPD/DS procedures not meeting the medical necessity criteria above</li> <li>▪ Loop gastric bypass</li> <li>▪ Mini gastric bypass</li> </ul> </li> </ul> </li> </ul>

COVERED SERVICES	SERVICE DESCRIPTION	COVERAGE LIMITS
		<ul style="list-style-type: none"> <li>▪ Roux-en-Y gastric bypass as a treatment for gastroesophageal reflux in nonobese persons</li> <li>▪ Silastic ring vertical gastric bypass (Fobi pouch)</li> <li>▪ Transoral endoscopic surgery (e.g., the StomaphyX device/procedure)</li> <li>▪ Vertical Banded Gastroplasty (VBG); and</li> <li>▪ Open or laparoscopic sleeve gastrectomy</li> </ul> <p>Precertification is required.</p>
<b>GENETIC TESTING OR DNA TESTING</b>	<p>Genetic testing services:</p> <ul style="list-style-type: none"> <li>• Evaluate the possibility of a genetic disorder</li> <li>• Diagnose such disorders</li> <li>• Counsel persons on these disorders</li> <li>• Follow persons who have or are thought to have disorders</li> </ul>	<p>Services are covered under the following:</p> <ul style="list-style-type: none"> <li>• There are signs and/or symptoms of an inherited disease in the affected individual.</li> <li>• There has been a physical examination, pretest counseling and other diagnostic studies.</li> <li>• The determination of the diagnosis in the absence of such testing remains uncertain and would impact the care and management of the individual on whom the testing is performed.</li> </ul> <p>Certain limits apply. Precertification may be required.</p>
<b>HEALTH CARE SERVICES (OFFICE VISITS, PREVENTIVE CARE AND SPECIALTY CARE)</b>	<ul style="list-style-type: none"> <li>• Physician services: professional services performed by physicians, including but not limited to surgery; consultation; diagnostic testing; and home, office and institutional calls.</li> <li>• Professional services: services rendered by primary care providers, specialists, nurse practitioners, physician assistants and other nonancillary providers.</li> </ul>	<p>Covered services must be provided by an Amerigroup network provider; referrals may be needed for certain services</p> <p>Covered services include:</p> <ul style="list-style-type: none"> <li>• Specialty physician services such as Screening Brief Intervention and Referral to Treatment (SBIRT)</li> <li>• Prenatal health promotion and methods to reduce risks as medically needed</li> <li>• Screening, diagnosis and treatment of sexually transmitted diseases as medically needed</li> <li>• HIV testing and counseling as medically needed</li> <li>• Prenatal Health Promotion and Risk Reduction (PHP/RR) services</li> <li>• Prenatal Health Promotion/Risk Reduction High Risk Nutrition (PHP/RRHRN) services</li> <li>• Prenatal Health Promotion/Risk Reduction Social Work Services (PHP/RRESW) services for pregnant and postpartum women</li> <li>• Dietitian services for Medicaid members under age 21 and CHIP members under age 19 when: <ul style="list-style-type: none"> <li>– Medically needed</li> </ul> </li> </ul>

COVERED SERVICES	SERVICE DESCRIPTION	COVERAGE LIMITS
		<ul style="list-style-type: none"> <li>– Provided by a registered dietitian licensed through the Kansas Department of Health and Environment and</li> <li>– Given as a result of a medical or dental screening referral</li> <li>• Labor and delivery in a maternity center setting for Medicaid members</li> <li>• Smoking cessation for pregnant women</li> <li>• Consults, office visits, and individual psychotherapy and pharmacological management services</li> </ul> <p>See the section <b>Medical Services for Members in Waiver Groups</b> for lab draw coverage for members in the Technology Assisted (TA) waiver group.</p>
<b>HOME HEALTH CARE</b>	<p>Nursing care in the home that requires the skills of a registered nurse and must be reasonable and necessary to the treatment of the patient's illness or injury. Home health skilled nursing services are differentiated from private duty nursing services in that skilled nursing services are supplied on an intermittent basis, generally through a home health agency.</p> <p>Services provided to the member in the home by an LPN. Licensed practical nurses have graduated from an approved school of practical (vocational) nursing, work under the supervision of registered nurses and/or physicians, and have been legally authorized to practice as a Licensed Practical Nurse (LPN).</p>	<p>Covered services include:</p> <ul style="list-style-type: none"> <li>• DME, home health, home infusion and medical supply services provided in the home</li> <li>• Home health skilled services provided for acute, intermittent, short-term and intensive courses of treatment, including: <ul style="list-style-type: none"> <li>– Full skilled nursing services</li> <li>– Brief skilled nursing visit if one of the following is performed: <ul style="list-style-type: none"> <li>▪ An injection</li> <li>▪ Blood draw or</li> <li>▪ Placement of medicine in containers</li> </ul> </li> </ul> </li> <li>• Home infusion therapy</li> <li>• Limited high-risk obstetrical services for a medical diagnosis that complicates pregnancy and may result in poor outcomes for the mother, unborn child or newborn</li> <li>• Physical, occupational, or speech and audiology services given in the home for members age 20 and younger when the member is not able to get these services in the local community</li> </ul> <p>Certain limits apply. Precertification is required for all services rendered by a home health agency.</p>
<b>HOME INFUSION (TOTAL PARENTERAL NUTRITION)</b>	<p>These services are provided by a licensed nurse to administer drugs, intravenous fluids, Total Parenteral Nutrition (TPN), etc. through an intravenous catheter.</p> <p>TPN may be given to people who are not able to absorb nutrients through the intestinal tract or to those undergoing high-dose chemotherapy or radiation and bone marrow transplants</p>	<p>Covered services include:</p> <ul style="list-style-type: none"> <li>• DME, home health, home infusion and medical supply services provided in the home</li> <li>• Parenteral nutrition, pumps and certain supplies when medically needed and prescribed</li> <li>• TPN for adult and children</li> <li>• Enteral or oral feedings <b>for Medicaid members under 21 and CHIP members</b></li> </ul>

COVERED SERVICES	SERVICE DESCRIPTION	COVERAGE LIMITS
		<p><b>under 19</b> when:</p> <ul style="list-style-type: none"> <li>– Enteral/oral nutrition makes up a small part of the person’s diet and/or</li> <li>– Person is being weaned from TPN feedings</li> </ul> <p>Precertification is required for all home infusion services rendered.</p> <p>See the section <b>Medical Services for Members in Waiver Groups</b> for Intermittent Intensive Medical Care coverage for members in the Technology Assisted (TA) waiver group.</p>
<p><b>HOSPICE CARE</b></p> <p>Amerigroup covers hospice care for members who choose it and have a terminal illness with a life expectancy of six months or less. Hospice care must be reasonable and necessary to manage the member’s illness and conditions.</p>	<p>Hospice care (or palliative care) is any form of medical care or treatment that concentrates on reducing the severity of the symptoms of a disease or slows its progress rather than providing a cure. It aims at improving quality of life by reducing or eliminating pain and other physical symptoms, enabling the patient to ease or resolve psychological and spiritual problems, and supporting the partner and family. Hospice care is multidisciplinary and includes home visits, professional medical help available on call, teaching and emotional support of the family, and physical care of the client. Some hospice programs provide care in a center as well as in the home.</p>	<p>Covered services include:</p> <ul style="list-style-type: none"> <li>• Nursing services</li> <li>• Medical social services</li> <li>• Counseling services for patients and their families, including dietary, spiritual and bereavement</li> <li>• Continuous home care when given to keep a person at home during a medical crisis; a minimum of eight hours of care during a 24-hour day, starting and ending at midnight, must be given</li> <li>• All drugs related to the patient’s terminal illness</li> </ul> <p>Members getting hospice care may be eligible for Home- and Community-Based Services; see the section <b>Medical Services for Members in Waiver Groups</b> for details.</p> <p>Precertification is required for all services rendered by a Hospice provider, including inpatient services rendered at nursing facilities.</p>
<p><b>HYPERBARIC OXYGEN THERAPY</b></p>	<p>Hyperbaric oxygen (HBO) therapy is a modality in which the entire body is exposed to oxygen under increased atmospheric pressure.</p>	<p>This therapy is used to treat:</p> <ul style="list-style-type: none"> <li>• Carbon monoxide poisoning</li> <li>• Air embolism</li> <li>• Smoke inhalation</li> <li>• Acute cyanide poisoning</li> <li>• Decompression sickness and</li> <li>• Certain cases of blood loss or anemia where increased oxygen transport may balance the blood deficiency</li> </ul> <p>Precertification is required.</p>
<p><b>IMMUNIZATIONS/ VACCINATIONS</b></p>		<ul style="list-style-type: none"> <li>• Immunizations for members age 18 and younger are covered through the Vaccines for Children (VFC) Amerigroup covers the administration fees associated with these immunizations. The SL modifier should not be used unless the State declares a vaccine shortage.</li> <li>• Coverage for adult vaccines is based on</li> </ul>



COVERED SERVICES	SERVICE DESCRIPTION	COVERAGE LIMITS
		<p>the Recommended Adult Immunization Schedule developed by the Centers for Disease Control's Advisory Committee on Immunization Practices (ACIP)</p> <p>Certain limits apply.</p>
<b>INPATIENT MEDICAL AND SURGICAL SERVICES</b>	<p>An acute medical facility is a hospital that treats patients in the acute phase of an illness or injury.</p> <p>An inpatient is a person who has been admitted to a hospital for bed occupancy for purposes of receiving inpatient hospital services.</p> <p>Generally, a patient is considered an inpatient if formally admitted as inpatient with the expectation that he or she will remain at least overnight and occupy a bed even though it later develops that the patient can be discharged or transferred to another hospital and not actually use a hospital bed overnight. The physician or other practitioner responsible for a patient's care at the hospital is also responsible for deciding whether the patient should be admitted as an inpatient. Physicians should use a 24-hour period as a benchmark, i.e., they should order admission for patients who are expected to need hospital care for 24 hours or more. Inpatient hospital services include bed and board, nursing services, diagnostic or therapeutic services, and medical or surgical services.</p>	<p>Inpatient hospital services include:</p> <ul style="list-style-type: none"> <li>• Bed and board</li> <li>• Nursing services</li> <li>• Diagnostic or therapeutic services and</li> <li>• Medical or surgical services</li> </ul> <p>Certain limits apply. Precertification is required for all services rendered by an inpatient hospital other than emergency services.</p>
<b>INTERMEDIATE CARE FACILITY FOR PEOPLE WITH INTELLECTUAL OR DEVELOPMENTAL DISABILITIES (ICF/IDD)</b>	<p>ICF/IDD are facilities that meet state licensure standards and provide habilitation-related care and service, prescribed by a physician, in conjunction with active treatment programming for members who are mentally retarded and who have related health and physical conditions.</p> <p>Services are reimbursed on a per diem rate as determined by the state.</p> <p>Covered services include:</p> <ul style="list-style-type: none"> <li>• Durable medical equipment</li> <li>• Over-the-counter pharmacy items</li> <li>• Occupational, physical, respiratory, speech and other therapies</li> <li>• Transportation</li> <li>• Miscellaneous services and supplies</li> </ul>	<p>Services provided by private ICFs/IDD are eligible for coverage. Members must have an approved level of care by the state to access this service. Certain limits apply.</p> <ul style="list-style-type: none"> <li>• One routine visit per month is covered in an ICF/IDD place of service by a physician or qualified health provider. Additionally, other services that are covered benefits, like hospice, home health, DME, etc. may be covered when delivered in an ICF/IDD place of service.</li> <li>• One history and physical is covered every 330 days per member in an ICF/IDD place of service.</li> <li>• If an ICF/IDD member is not admitted to a hospital but for observation purposes only, it is considered an approved ICF/IDD day and not a hospital or therapeutic reserve day.</li> </ul>

COVERED SERVICES	SERVICE DESCRIPTION	COVERAGE LIMITS
<b>MEDICAL SUPPLIES</b>	<p>Medical supplies are generally disposable/consumable items designed for use by a single individual. These may include but are not limited to dressing materials, suction tubing, syringes, incontinence supplies, ostomy supplies and burn pressure garments.</p>	<ul style="list-style-type: none"> <li>• A maximum of 21 nonmedical reserve days are allowed per calendar year for ICF/IDD.</li> </ul> <p>Outpatient medical supply services are covered, including:</p> <ul style="list-style-type: none"> <li>• Antiseptics and germicides</li> <li>• Bandages, dressings and tapes</li> <li>• Suction</li> <li>• Batteries/replacement batteries for wheelchairs, speech-generating devices and ventilators</li> <li>• Blood monitoring/testing supplies, including blood glucose monitors</li> <li>• Braces, belts and supportive devices</li> <li>• Syringes and needles</li> <li>• Urological supplies, including diapers and related supplies (disposable incontinent products include briefs; diapers; pull-up pants; underpads for beds; liners, shields, guards, pads and undergarments, which are covered for incontinence only); covered for members ages 5 to 20 only; prior approval is required</li> <li>• Urological supplies for urinary retention</li> <li>• Bilirubin light therapy supplies</li> </ul> <p>Certain limits apply. Precertification may be required. Members in some waiver groups will be eligible for added services.</p>
<b>NURSING FACILITY SERVICES</b>	<p>A facility (which meets specific regulatory certification requirements) which primarily provide inpatient skilled nursing care and related services to patients who require medical, nursing, or rehabilitative services but does not provide the level of care or treatment available in a hospital</p> <p>Kansas Medicaid does not make a distinction between skilled nursing facilities and nursing facilities.</p>	<p>Covered services include:</p> <ul style="list-style-type: none"> <li>• Services provided at licensed nursing facilities when the individual has been determined to meet the clinical and financial eligibility criteria for nursing facility level of care or when Amerigroup determines the nursing facility level of care criteria has been satisfied for a member requiring a short-term placement for skilled or physical rehabilitation or other services</li> <li>• Nursing facility services are generally limited to those 21 years of age and older, do not otherwise meet the criteria for NF/MH or ICF/IDD facilities, and whose needs cannot be met in a community setting and/or do not require an acute level of care.</li> <li>• Short-term placements may occur for any adult member.</li> <li>• Only one nursing facility will be paid for the same member and the same date of service.</li> <li>• Nursing facilities will not be reimbursed for providing dental services.</li> </ul>

COVERED SERVICES	SERVICE DESCRIPTION	COVERAGE LIMITS
		<ul style="list-style-type: none"> <li>• A member with an ACHN indicator (member resides in an adult care home) on his/her eligibility record is not eligible for Medicaid payments for his or her nursing facility services.</li> <li>• NF/ICF or ICF/IDD services are not covered during the hospice-election time frame.</li> <li>• Services in nursing facilities for mental health are not covered under the state's contract with Amerigroup for individuals aged 22 through 64, but may be covered under fee-for-service for Medicaid-eligible persons. These providers are identified with KMAP provider type 03 and KMAP provider specialty 011 (LOC 230 &amp; 231).</li> <li>• A maximum of 18 home leave days for NFs are allowed per calendar year.</li> </ul>
<b>OBSERVATION SERVICES</b>	<p>Services furnished by a network hospital on the hospital's premises, including use of a bed and periodic monitoring by a hospital's nursing or other staff which are reasonable and necessary to evaluate a patient's condition or determine the need for a possible admission to the hospital as an inpatient. Observation is an outpatient service, including behavioral and medical.</p>	<p>Covered services include:</p> <ul style="list-style-type: none"> <li>• Use of a bed and periodic monitoring by a hospital's nursing or other staff, needed to assess a member's condition or decide the need for a possible inpatient hospital admission; observation is an outpatient service</li> </ul> <p>Exclusions include:</p> <ul style="list-style-type: none"> <li>• Observation room is not covered for the following: <ul style="list-style-type: none"> <li>– Minor surgery</li> <li>– Recovery room services following inpatient or outpatient surgery</li> <li>– Recovery/observation following scheduled diagnostic tests such as arteriograms, cardiac catheterization, etc.</li> <li>– Scheduled fetal oxytocin stress tests and fetal nonstress tests</li> <li>– ER physician fee</li> <li>– Non-psychiatric observation is billed by the hour, up to a maximum of 48 hours per incident; use CPT code G0378; 1 unit = 1 hour</li> <li>– Psychiatric observation is billed using H2013; 1 unit = 1 day, for a maximum of two consecutive days</li> </ul> </li> </ul> <p>Medical supplies used in conjunction with outpatient surgery and/or the ER or observation room are considered content of service and cannot be billed separately.</p> <ul style="list-style-type: none"> <li>• When an inpatient hospital admission follows a psychiatric observation stay, the observation days are content of service of the inpatient reimbursement.</li> </ul>

COVERED SERVICES	SERVICE DESCRIPTION	COVERAGE LIMITS
<b>OUTPATIENT SERVICES</b>	Preventive, diagnostic, therapeutic, palliative care and other services provided to a member in the outpatient portion of a health facility	<p>Covered services include:</p> <ul style="list-style-type: none"> <li>Those that can be properly given on an outpatient or ambulatory basis such as: <ul style="list-style-type: none"> <li>Preventive care</li> <li>Lab and radiology services</li> <li>Therapies</li> <li>Ambulatory surgery</li> </ul> </li> <li>Observation services, if needed to decide whether a member should be admitted to the hospital</li> </ul> <p>Certain limits apply. Precertification required for most services other than lab services.</p>
<b>PAIN MANAGEMENT</b>	<p>Pain management is the whole system of care and treatment of a state of pain.</p> <p>Services for the sole purpose of pain management are not covered.</p>	<p>Covered services include but are not limited to:</p> <ul style="list-style-type: none"> <li>Implantable Infusion Pumps</li> <li>Implantable Drug Delivery Systems when medically needed for cancer pain and spasms related to cancer</li> </ul> <p>Precertification is required.</p>
<b>PODIATRY</b>	Podiatry is the diagnosis, treatment and prevention of conditions of the human feet.	<p><b>Medicaid members under age 21 and CHIP members under age 19</b> are eligible to receive:</p> <ul style="list-style-type: none"> <li>Podiatry services</li> <li>Medically needed consult services and</li> <li>Medically needed elective surgery (precertification required)</li> </ul>
<b>PREVENTIVE HEALTH SERVICES – ADULT</b>	Preventative health examinations and services serve to deter the occurrence of an adverse condition or disease. This may include but is not limited to a routine physical, an examination of the bodily functions and condition of an individual; generally, patient symptomatology or complaints do not precipitate the visit.	<p>Covered services include:</p> <ul style="list-style-type: none"> <li>Routine physicals</li> <li>Physical exams when the exam is one or more of the following: <ul style="list-style-type: none"> <li>A screening exam covered by the EPSDT program for adults age 18 up to age 21</li> <li>An annual exam for members with disabilities</li> <li>A screening Pap smear, mammogram or prostate exam</li> </ul> </li> </ul>
<b>PROSTHETICS AND ORTHOTICS</b>	<ul style="list-style-type: none"> <li>Orthotics: a support, brace or splint used to support, align, prevent or correct the function of movable parts of the body. Shoe inserts are orthotics that are intended to correct an abnormal or irregular walking pattern by altering slightly the angles at which the foot strikes a walking or running surface. Other orthotics include neck braces, lumbosacral supports, knee braces and wrist supports.</li> <li>Prosthetics: Prosthetic devices are artificial devices or appliances that replace all or part of a permanently inoperative or missing body part.</li> </ul>	<p>Covered services include:</p> <ul style="list-style-type: none"> <li>Replacement, corrective or supportive devices prescribed by a physician or other licensed practitioner to: <ul style="list-style-type: none"> <li>Artificially replace a missing portion of the body</li> <li>Prevent or correct physical deformity or malfunction or</li> <li>Support a weak or deformed portion of the body</li> </ul> </li> <li>Repair or change to a current prosthesis; a replacement prosthesis is only covered when the purchase of a replacement is less costly than repairing or modifying the current prosthesis</li> <li>Custom-fitted and/or custom-molded orthotic devices to treat certain conditions</li> <li>Ocular prosthetics for eligible members</li> </ul>

COVERED SERVICES	SERVICE DESCRIPTION	COVERAGE LIMITS
		<p>when provided by an ophthalmologist, an oculist or an optometrist who specializes in prosthetics</p> <p>Certain limits apply. Precertification is required.</p>
<b>REHABILITATION THERAPY SERVICES</b>	<p>Performed in home or outpatient setting:</p> <ul style="list-style-type: none"> <li>• Occupational Therapy (OT): based on engagement in meaningful activities of daily life (as self-care skills, education, work or social interaction) especially to enable or encourage participation in such activities despite impairments or limitations in physical or mental functioning.</li> <li>• Physical Therapy (PT): the treatment of disease by physical and mechanical means (as massage, regulated exercise, water, light, heat, and electricity); also called physiotherapy. It is a branch of treatment that uses physical means to relieve pain, regain range of movement, restore muscle strength and return patients to normal activities of daily living.</li> <li>• Respiratory Therapy (RT): assessment and therapeutic treatment of respiratory diseases; may include but is not limited to airway management, mechanical ventilation, blood acid/base balance and critical care medicine. RT also includes pulmonary rehabilitation designed for people who have chronic lung disease; the primary goal is to achieve and maintain the maximum level of independence and functioning. Although most pulmonary rehabilitation programs focus on the needs of people who have COPD, people with other types of lung disease may benefit as well.</li> <li>• Speech Therapy (ST): rehabilitative or corrective treatment of physical and/or cognitive deficits/disorders resulting in difficulty with communication and/or swallowing.</li> </ul>	<p>Covered services include:</p> <ul style="list-style-type: none"> <li>• Physical therapy</li> <li>• Occupational therapy</li> <li>• Speech therapy</li> <li>• Respiratory therapy</li> </ul> <p>These services must:</p> <ul style="list-style-type: none"> <li>• Be prescribed by the member's PCP or attending physician for an acute condition</li> <li>• Make it possible for the member to improve as a result of rehab</li> </ul> <p>Precertification is required.</p> <p>Members in some waiver groups may be eligible for added services.</p> <p>Amerigroup covers developmental physical therapy, developmental occupational therapy, and developmental speech therapy services for children under age 21 for certain designated diagnoses that include birth defects, Autism Spectrum Disorders, and other developmental delays. Prior authorization is required. Periodic re-evaluations and assessments are required at least every six months and continuous improvement must be shown in order to qualify for continued treatment.</p>
<b>SELF-REFERRAL SERVICES</b> These covered services are given to members without referrals from their Primary Care Provider (PCP) or precertification from Amerigroup. These services can be accessed from a provider other than	<p>Services rendered to a member without requiring a referral by the PCP or MCO, when the member accesses the service through a provider other than the member's PCP.</p>	<p>A member may choose to receive the following self-referral services from a local health department or family planning clinic:</p> <ul style="list-style-type: none"> <li>• Family planning services and birth control</li> <li>• HIV and AIDS testing</li> <li>• Immunizations</li> <li>• Sexually-transmitted disease screening and treatment services</li> <li>• Tuberculosis screening and follow-up care</li> </ul>

COVERED SERVICES	SERVICE DESCRIPTION	COVERAGE LIMITS
a member's PCP.		<ul style="list-style-type: none"> <li>Indian Health services</li> </ul> <p>Amerigroup covers two sessions of risk factor reduction counseling for HIV/AIDS per member, each time tested.</p>
<b>SMOKING CESSATION PROGRAMS/SUPPLIES</b>	Smoking cessation programs provide counseling and patient education as to the health risks of smoking and specific information related to the risks of specific diseases. Also includes items such as nicotine patches, gum or other non-smoking aids.	<p>Covered products include:</p> <ul style="list-style-type: none"> <li>Nicotine patches</li> <li>Prescription medication to manage withdrawal and other effects</li> <li>Nicotine gum, oral nicotine and nasal inhalers</li> <li>Nicotine inhalers and Chantix® are covered for maximum of 24 weeks; all other smoking cessation products are covered for a maximum of 12 weeks of therapy per year</li> </ul>
<b>STERILIZATION AND REVERSAL/ HYSTERECTOMY</b>		<p>Amerigroup covers sterilizations and hysterectomies in accordance with federal (CMS) requirements.</p> <p><b>Sterilization is covered only if:</b></p> <ul style="list-style-type: none"> <li>A person is at least 21 years old at the time consent is given</li> <li>A person is not mentally incompetent</li> <li>A person has voluntarily given written informed consent and</li> <li>At least 30 days, but not more than 180 days, have passed between the date of informed consent and the date of the sterilization, except in the case of premature delivery or emergency abdominal surgery <ul style="list-style-type: none"> <li>An individual may consent to be sterilized at the time of a premature delivery or emergency abdominal surgery if at least 72 hours have passed since he or she gave informed consent for the sterilization</li> <li>In the case of premature delivery, the informed consent must have been given at least 30 days before the expected date of delivery</li> </ul> </li> </ul> <p><b>Sterilization by hysterectomy is covered only if:</b></p> <ul style="list-style-type: none"> <li>A person was already sterile before the hysterectomy or</li> <li>A person requires a hysterectomy because of a life-threatening emergency situation in which the physician decides that prior acknowledgment is not possible</li> </ul> <p>Documentation of informed consent is required and may not be obtained when the</p>

COVERED SERVICES	SERVICE DESCRIPTION	COVERAGE LIMITS
		<p>person to be sterilized is either/or:</p> <ul style="list-style-type: none"> <li>• In labor or childbirth</li> <li>• Seeking to obtain or obtaining an abortion</li> <li>• Under the influence of alcohol or other substances that affect the person's state of awareness</li> </ul> <p>Sterilization of a mentally incompetent or institutionalized person is covered if:</p> <ul style="list-style-type: none"> <li>• A court order states the person is to be sterilized and indicates the name of the person's legal guardian who will be giving consent for the sterilization and</li> <li>• The sterilization consent form is signed by the person's legal guardian</li> </ul> <p>Hysterectomies</p> <ul style="list-style-type: none"> <li>• Are paid only for medical reasons unrelated to sterilization</li> <li>• Require consent documentation, regardless of the person's age or diagnosis, the State requires a Consent for Sterilization form. The form is available under the Consent heading on the Forms page of the KMAP website. <ul style="list-style-type: none"> <li>– Consent for Sterilization form (i.e., verbiage acknowledging that surgery will make member permanently incapable of reproducing) is attached to claim or a previously received claim related to the procedure.</li> <li>– Physician provides written certification that the member was already sterile and states the cause of sterility. A statement on the face of the claim is acceptable if the claim is signed by the physician or has his/her stamped signature.</li> <li>– Physician provides written certification that the surgery was performed under life-threatening situation (including a description of the nature of the emergency). In addition, a statement made on the face of the claim must indicate that the situation was "life-threatening".</li> </ul> </li> </ul> <p>Hysteroscopic sterilizations must be performed by a Health Resources and Services Administration-approved Center of Excellence provider.</p> <p>Precertification is required.</p>
<b>TRANSPORTATION</b>	<ul style="list-style-type: none"> <li>• Emergency: Transportation requiring emergency response includes transportation from a provider's office to a</li> </ul>	<p>Nonemergency nonambulance transportation to and from covered medical services is covered; based on need, these forms of</p>

COVERED SERVICES	SERVICE DESCRIPTION	COVERAGE LIMITS
	<p>facility for direct admission. Emergency response means responding immediately at the BLS or ALS level of service to a 911 call or the equivalent in areas without a 911-call system. An immediate response is one in which the ambulance entity begins as quickly as possible to take the steps necessary to respond to the call.</p> <p>Includes mileage, supplies, services and medication administration as required. Also includes rotary wing ambulance (helicopter), fixed wing air ambulance (aircraft), and specialty care transport which is ground ambulance supplying services beyond the level of EMT-paramedic such as nursing, respiratory care, emergency medicine or cardiovascular care; to include behavioral health ambulance.</p> <ul style="list-style-type: none"> <li>• Nonemergency: a ride, or reimbursement for a ride, provided so that a member with no other transportation resources can receive services from a medical provider. Nonemergency transportation does not include transportation provided on an emergency basis, such as trips to the emergency room in life threatening situations; may include but is not limited to taxi, bus or van transport.</li> </ul>	<p>transportation may include:</p> <ul style="list-style-type: none"> <li>• Taxi</li> <li>• Sedan</li> <li>• Wheelchair van</li> <li>• Public transportation</li> <li>• Gas reimbursement</li> </ul> <p>Ambulance transportation to and from covered medical services are covered when the transportation is:</p> <ul style="list-style-type: none"> <li>• Within the scope of an eligible member's medical care program</li> <li>• Medically needed based on the member's condition at the time of the ambulance trip and as recorded in the member's record</li> <li>• Right for the member's actual medical need</li> </ul> <p>Coverage is limited to medically needed ambulance transportation when a member cannot be safely or legally transported any other way. If a member can safely travel by car, van, taxi or other means, the ambulance trip is not medically needed, and the ambulance service is not covered.</p> <p><b>Ground or water ambulance services</b> Services are covered when the eligible member:</p> <ul style="list-style-type: none"> <li>• Has an emergency medical need for transportation</li> <li>• Needs medical care during the trip</li> <li>• Must be taken by stretcher or gurney or</li> <li>• Needs to be transferred from one hospital to another and the transferring or discharging hospital does not offer the right facilities for the medical services the member needs</li> </ul> <p>Ambulance coverage includes:</p> <ul style="list-style-type: none"> <li>• Specialty care transport, which is hospital-to-hospital transport by ground ambulance of a critically injured or ill member at a level of service beyond the scope of a paramedic</li> </ul> <p><b>Air ambulance (rotary or fixed-wing aircraft) services</b> Services are covered when:</p> <ul style="list-style-type: none"> <li>• The needed medical treatment cannot be accessed locally or the member's point of pickup cannot be accessed by ground</li> <li>• The vehicle and crew meet the provider requirements</li> <li>• The member must be taken to an acute care hospital and</li> <li>• The member's physical and medical</li> </ul>



COVERED SERVICES	SERVICE DESCRIPTION	COVERAGE LIMITS
		<p>condition</p> <ul style="list-style-type: none"> <li>– Require immediate and rapid ambulance transportation that cannot be given by ground ambulance or</li> <li>– Does not allow for safe travel on a commercial flight</li> </ul> <p>In certain cases, air ambulance is covered when it is decided it is less costly than ground ambulance.</p> <p>Air ambulance transportation for hospital transfers is covered only if transportation by ground ambulance would endanger the member's life or health.</p>
<b>TRANSPLANTS</b>		<p>These services are covered for members diagnosed with certain medical conditions. Services include:</p> <ul style="list-style-type: none"> <li>• Reviewing pretransplant inpatient or outpatient needs</li> <li>• Searching for donors</li> <li>• Choosing and getting organs/tissues</li> <li>• Preparing for and performing transplants, including: <ul style="list-style-type: none"> <li>– Heart–Lung</li> <li>– Kidney–Bone marrow</li> <li>– Liver–Small bowel</li> <li>– Pancreas</li> </ul> </li> <li>• Outpatient follow-up care</li> </ul> <p>Certain limits apply. Precertification is required.</p>
<b>URGENT CARE SERVICES</b>		<p>Covered services include:</p> <ul style="list-style-type: none"> <li>• Services given within 12 hours to avoid the onset of an emergency medical condition</li> <li>• Services given at a location designated as an urgent care facility</li> </ul>
<b>VISION OPHTHALMOLOGY</b>	<ul style="list-style-type: none"> <li>• Ophthalmology: the branch of medicine which deals with the diseases and surgery of the visual pathways, including the eye, brain and areas surrounding the eye.</li> <li>• Glaucoma screening: Glaucoma represents a family of eye diseases commonly associated with optic nerve damage and visual field changes (a narrowing of the eyes' usual scope of vision).</li> </ul>	<p>Covered services include:</p> <ul style="list-style-type: none"> <li>• Routine medical/surgical vision services</li> <li>• Exams and refraction services outside the specified limits if one of the following applies: <ul style="list-style-type: none"> <li>– A provider is diagnosing or treating a member for a medical condition that has symptoms of vision problems or disease</li> <li>– The member is on medicine that affects vision</li> </ul> </li> <li>• Visual field exams for the diagnosis and treatment of abnormal signs, symptoms or injuries</li> <li>• Orthoptic and vision therapy, which takes in a range of treatments, including lenses, prisms, filters, patching, and eye exercises</li> </ul>

COVERED SERVICES	SERVICE DESCRIPTION	COVERAGE LIMITS
		<p>and vision training used for eye movement and fixation training</p> <ul style="list-style-type: none"> <li>• Ocular prosthetics for eligible members when given by an ophthalmologist, an oculist or an optometrist who specializes in prosthetics</li> <li>• Cataract surgery when certain clinical criteria are met</li> <li>• Strabismus surgery (a condition in which the eyes are not properly aligned): <ul style="list-style-type: none"> <li>– For eligible members age 17 and younger</li> <li>– For eligible members age 18 and older when the member has double vision and the surgery is not performed for cosmetic reasons</li> </ul> </li> <li>• Blepharoplasty or blepharoptosis surgery when: <ul style="list-style-type: none"> <li>– The member's excess upper eyelid skin is blocking the superior visual field and</li> <li>– The blocked vision is within 10 degrees of central fixation using a central visual field test</li> </ul> </li> </ul> <p>Precertification is required. The requirement is based on the CPT/HCPCS code and can be found in our online precertification look-up tool.</p>
<b>VISION OPTOMETRY</b>	<ul style="list-style-type: none"> <li>• Optometry: a health care profession concerned with examination, diagnosis and treatment of the eyes and related structures and with determination and correction of vision problems using lenses and other optical aids.</li> <li>• Routine examinations: Vision services include visual examination; fitting, dispensing and adjustment of eyeglasses; follow-up examinations; and contact lenses.</li> <li>• Glaucoma screening: Glaucoma represents a family of eye diseases commonly associated with optic nerve damage and visual field changes (a narrowing of the eyes' usual scope of vision).</li> </ul>	<p>Covered services include:</p> <ul style="list-style-type: none"> <li>• Eye exams and refraction and fitting services: <ul style="list-style-type: none"> <li>– Once every 12 months for members age 21 and older</li> <li>– Once every 12 months for members age 20 and younger or more frequently if medically necessary</li> </ul> </li> <li>• Glasses are covered: <ul style="list-style-type: none"> <li>– Once every 12 months for members age 21 and older</li> <li>– Once every 12 months for members age 20 and younger or as medically necessary up to three pairs per year</li> </ul> </li> <li>• Repair and adjustment of glasses are covered as needed for all members.</li> <li>• Contact lenses and replacements are covered with prior authorization for the following (medical necessity must be present): <ul style="list-style-type: none"> <li>– Monocular aphakia</li> <li>– Bullous keratopathy</li> <li>– Keratoconus</li> <li>– Corneal transplant</li> <li>– Anisometropia of more than three</li> </ul> </li> </ul>

COVERED SERVICES	SERVICE DESCRIPTION	COVERAGE LIMITS
		<p>dipters of difference that is causing vision distortion and cannot be corrected with glasses</p> <ul style="list-style-type: none"> <li>• Contact lens adaptation includes six months of care.</li> <li>• Contact lens replacement includes neutralization per lens.</li> <li>• Contact lenses are noncovered for cosmetic purposes or for athletic participation. Contact sunglasses, colored or tinted of any kind, are noncovered.</li> <li>• Contact lens fitting is allowed once per lifetime when contacts are first prescribed. Subsequent fittings will be considered if a new type of contact lens is being prescribed and fitted.</li> </ul> <p>Members may not pay extra to upgrade your glasses or frames. Precertification is required. The requirement is based on the CPT/HCPCS code and can be found in our online precertification look-up tool.</p>
<b>WELL-WOMAN SERVICES</b>	<p>A healthy lifestyle includes having regular gynecologic exams and screening tests for disorders that can be prevented or treated well if found early.</p> <p>Services must:</p> <ul style="list-style-type: none"> <li>• Be obtained from an Amerigroup network provider</li> <li>• Include follow-up treatment for any problems found</li> </ul>	<p>Covered services include:</p> <ul style="list-style-type: none"> <li>• Annual mammogram screening for women age 40 and older; precertification is required for women age 39 and younger</li> <li>• Annual Pap test</li> </ul>
<b>WOMEN'S HEALTH</b>		<p>Abortion is covered only:</p> <ul style="list-style-type: none"> <li>• If the pregnancy is the result of an act of rape or incest, or</li> <li>• In the case where a woman suffers from a physical disorder, physical injury, or physical illness, including a life-endangering physical condition caused by or arising from the pregnancy itself, that would as certified by a physician, place the woman in danger of death unless an abortion is performed.</li> <li>• Precertification may be required.</li> <li>• Spontaneous abortion (miscarriage) is covered.</li> </ul>
<b>SERVICES FOR MEMBERS IN WAIVER GROUPS</b>	<p>As one of the country's leading managed care organizations for the elderly and people with disabilities, we're committed to serving our members residing in nursing facilities and those enrolled in waiver programs.</p>	<p>The state decides who's eligible for these programs. They include the Autism, Technology Assisted, Physically Disabled, Frail Elderly, Traumatic Brain Injury, Serious Emotional Disturbance and Intellectually/Developmentally Disabled waivers</p>

COVERED SERVICES	SERVICE DESCRIPTION	COVERAGE LIMITS
<b>AUTISM WAIVER</b>	<p>The HCBS/Autism Waiver provides services to Medicaid-eligible children with autism from 0–5 years of age (at the time of the application) who are at risk of admission to an inpatient psychiatric facility. This service is designed to provide children with Autism Spectrum Disorders (ASD) early intensive intervention treatment and to allow primary caregivers to receive needed support through services. Children receiving waiver services must be diagnosed using an approved autism-specific screening tool and meet the functional criteria using the Vineland II Survey Interview Form.</p>	<p>Covered services include:</p> <ul style="list-style-type: none"> <li>• Clinical and therapeutic consult services</li> <li>• Intensive Individual Support (IIS)</li> <li>• Respite services for a family member who serves as the primary caregiver to the member and is not paid to provide these services</li> <li>• Parent support and training</li> <li>• Family adjustment counseling</li> <li>• Interpersonal communication therapy</li> </ul> <p><b>Certain limits apply:</b></p> <ul style="list-style-type: none"> <li>• Clinical and therapeutic consult services: max. of 50 hours per child per calendar year</li> <li>• Family adjustment counseling: max. of 12 hours per calendar year</li> <li>• Intensive individual support services: max. of 25 hours per week per calendar year</li> <li>• Interpersonal communication therapy services are covered up to a max. of eight units (max. of two hours) per child per calendar week.</li> <li>• Parent support and training services: max. of 30 hours per calendar year</li> <li>• Respite care services: max. of 168 hours per child per calendar year</li> <li>• Additional units can be accessed with Program Manager approval.</li> </ul> <p>All Autism Waiver services require precertification.</p>
<b>PHYSICAL DISABILITY WAIVER</b>	<p>This benefit:</p> <ul style="list-style-type: none"> <li>• Serves persons ages 16–65 who would otherwise require care in a nursing facility</li> <li>• Allows eligible members to access community services and make choices to be more independent</li> </ul> <p>Persons served by this waiver include:</p> <ul style="list-style-type: none"> <li>• Those eligible for Medicaid</li> <li>• Those who qualify as disabled through Social Security</li> <li>• Those in need of long-term services and supports to meet the normal activities of daily living</li> </ul> <p>The state of Kansas decides who is eligible.</p>	<p>Covered services include:</p> <p><b>Members ages 16–65 in the PD Waiver:</b></p> <ul style="list-style-type: none"> <li>• Assistive services</li> <li>• Personal Care Services (PSC)</li> <li>• Home-delivered meals</li> <li>• Medicine reminder services</li> <li>• Personal emergency response system and installation</li> <li>• Enhanced Care Services (ECS) support</li> </ul> <p><b>Assistive services to meet a member's assessed needs:</b></p> <ul style="list-style-type: none"> <li>• Changing or improving a member's home and/or</li> <li>• Providing adaptive equipment or hardware such as: <ul style="list-style-type: none"> <li>– Technology assistance devices</li> <li>– Adaptive equipment or</li> <li>– Environmental changes to the home</li> </ul> </li> </ul> <p>Assistive services may include:</p> <ul style="list-style-type: none"> <li>• Ramps or lifts</li> <li>• Changes to bathrooms and kitchens to improve access</li> </ul>

COVERED SERVICES	SERVICE DESCRIPTION	COVERAGE LIMITS
		<ul style="list-style-type: none"> <li>• Special changes for safety and</li> <li>• Devices to improve mobility or communication</li> </ul> <p><b>Certain limits apply:</b></p> <ul style="list-style-type: none"> <li>• Home modification and assistive technology services: max. lifetime benefit of \$7,500 per member; services covered under the Money Follows the Person Grant do not count toward this lifetime maximum</li> <li>• Home-delivered meals: max. of two meals per calendar date</li> <li>• Medication reminder/dispenser: max. of one installation per member per calendar year</li> <li>• Personal emergency response systems: max. of two installations per calendar year</li> <li>• Personal services: max. of 10 hours per 24-hour period absent precertification exception</li> <li>• Enhanced Care Services (ECS) support period: min. six hours in length; max. of 12 hours during any 24-hour period</li> </ul> <p><b>Money Follows the Person Grant services for those in the PD Waiver:</b></p> <ul style="list-style-type: none"> <li>• Transition service</li> <li>• Transition coordination service</li> <li>• Community bridge building</li> <li>• Community transition counseling and</li> <li>• Assistive services</li> </ul> <p><b>Financial Management Services (FMS):</b> For more details, see the FMS Appendix of this manual.</p> <p>All services require prior authorization.</p> <ul style="list-style-type: none"> <li>•</li> </ul>
<b>TECHNOLOGY ASSISTED WAIVER</b>	<p>This benefit:</p> <ul style="list-style-type: none"> <li>• Serves persons ages 0–21 who: <ul style="list-style-type: none"> <li>– Are chronically ill or medically fragile</li> <li>– Depend on a ventilator or medical device to make up for the loss of vital bodily function</li> <li>– Require extensive ongoing daily care to help prevent further disability or death, such as the level of care given in a hospital setting, by: <ul style="list-style-type: none"> <li>▪ A nurse or</li> <li>▪ Other qualified caregiver under the guidance of a nurse</li> </ul> </li> </ul> </li> <li>• Helps children in need of care get long-term medical care at home and lowers or ends the need for: <ul style="list-style-type: none"> <li>– Long-term hospital or institutional</li> </ul> </li> </ul>	<p><b>TA Waiver Services</b></p> <p>These services include:</p> <ul style="list-style-type: none"> <li>• Specialized medical care through a registered nurse or licensed practical nurse</li> <li>• Help, through long-term community personal care services, with: <ul style="list-style-type: none"> <li>– Activities of daily living such as bathing, grooming and toileting</li> <li>– Health maintenance activities, including therapies, feeding, walking and exercising, and social and recreation activities</li> </ul> </li> <li>• Medical respite, offered in the member's place of residence</li> <li>• Home modification services</li> <li>• Intermittent Intensive Medical Care (IIMC)</li> </ul>

COVERED SERVICES	SERVICE DESCRIPTION	COVERAGE LIMITS
	<p>care and/or</p> <p>Frequent hospital stays for acute care reasons</p>	<ul style="list-style-type: none"> <li>• Health Maintenance Monitoring (HMM)</li> </ul> <p><b>Intermittent Intensive Medical Care (IIMC)</b></p> <p>These services are given by a registered nurse and offer a member:</p> <ul style="list-style-type: none"> <li>• Routine health maintenance care through an attendant level of care</li> <li>• The choice to: <ul style="list-style-type: none"> <li>– Have certain skilled nursing care needs met that cannot be given by an attendant</li> <li>– Receive IIMC services along with agency or self-directed personal care services (PCS)</li> </ul> </li> </ul> <p>Services include but are not limited to:</p> <ul style="list-style-type: none"> <li>• Intravenous (IV) therapy, given less than every four hours each day</li> <li>• IV therapy, given less than four hours per day, weekly or monthly</li> <li>• Total parenteral nutrition (TPN), central line given less than four hours each day</li> <li>• Blood product, given less than four hours each day, intermittently, weekly or monthly</li> <li>• IV pain control, given less than four hours each day</li> <li>• Lab draw each peripheral</li> <li>• Lab draw each central</li> <li>• Chemotherapy IV or injection and</li> <li>• Home dialysis</li> </ul> <p><b>Specialized Medical Care</b></p> <p>These services help members who are:</p> <ul style="list-style-type: none"> <li>• Medically fragile and</li> <li>• Technology-dependent</li> </ul> <p>Through these services, a member receives:</p> <ul style="list-style-type: none"> <li>• Long-term nursing support for ongoing daily care, as in a hospital</li> <li>• Help with intensive medical needs so he or she can choose to live outside of a hospital or an institutional setting</li> </ul> <p>Most of these services are offered in community locations where a beneficiary:</p> <ul style="list-style-type: none"> <li>• Lives</li> <li>• Attends school or child care</li> <li>• Socializes</li> </ul> <p><b>Long-term Community Care Personal Care Services (PCS)</b></p> <p>These services give members the choice to stay in their home while living with medical limits. With the help of a long-term care community attendant, the member can:</p>

COVERED SERVICES	SERVICE DESCRIPTION	COVERAGE LIMITS
		<ul style="list-style-type: none"> <li>• Access covered medical services</li> <li>• Get support with normal daily activities usually done by a parent, legal guardian or caretaker</li> <li>• Get a ride to accomplish tasks and/or access covered services</li> </ul> <p><b>Agency-directed personal care services (PCS):</b></p> <ul style="list-style-type: none"> <li>• Arranged by a Long-term Service Supports Coordinator</li> <li>• Performed by a Medical Service Technician (MST)</li> </ul> <p><b>Self-directed personal care services (PCS):</b></p> <ul style="list-style-type: none"> <li>• Arranged for and purchased under the member's or responsible party's written approval</li> <li>• Performed by personal care services (PCS)</li> </ul> <p>The member, or the responsible party who has the right to direct services, can decide to:</p> <ul style="list-style-type: none"> <li>• No longer self-direct services and</li> <li>• Receive prior approved waiver services without penalty</li> </ul> <p><b>Medical Respite Services</b> These services:</p> <ul style="list-style-type: none"> <li>• Offer the member's family short, distinct periods of relief</li> <li>• Are covered when given where the member lives</li> </ul> <p><b>Home Modification Services</b> Covered services include changes to the home to help the member in day-to-day functions; examples are:</p> <ul style="list-style-type: none"> <li>• Purchase or rental of new or used transfer lift</li> <li>• Purchase of or installation of ramp not covered by any other resources</li> <li>• Widening of doorways</li> <li>• Changes to bathroom facilities where the member lives</li> </ul> <p>The goal is to help the member maintain:</p> <ul style="list-style-type: none"> <li>• Independence</li> <li>• Mobility and</li> <li>• Productivity in the community</li> </ul> <p><b>Certain limits apply:</b></p> <ul style="list-style-type: none"> <li>• Specialized medical care: max. of 252 hours or 1,008 units* per month per beneficiary; extensions may be approved when medically needed</li> <li>• Long-term community personal care services (PCS): max. of 372 hours or 1,488</li> </ul>

COVERED SERVICES	SERVICE DESCRIPTION	COVERAGE LIMITS
		units* per month per member <ul style="list-style-type: none"> <li>• Medical respite care: max. of 168 hours or 672 units per calendar year</li> <li>• Home modification services: limits include a maximum lifetime benefit of \$7,500 per member</li> </ul> *One unit equals 15 minutes. All services require precertification.
<b>TRAUMATIC BRAIN INJURY WAIVER</b>	This benefit: <ul style="list-style-type: none"> <li>• Serves persons ages 16–65 who would otherwise need to be placed in a Traumatic Brain Injury (TBI) rehabilitation facility</li> <li>• Gives eligible persons the chance to rebuild their lives through:               <ul style="list-style-type: none"> <li>– Supports</li> <li>– Therapies</li> <li>– Services designed to build independence</li> </ul> </li> </ul>	<b>TBI Waiver Services:</b> These services include: <ul style="list-style-type: none"> <li>• Transitional living skills</li> <li>• Personal care services (PCS)</li> <li>• Home delivered meals</li> <li>• Medicine reminder call</li> <li>• Medicine reminder dispenser and setup</li> <li>• Assistive services (for those members who have situations defined as critical)</li> <li>• Rehab therapies, including:               <ul style="list-style-type: none"> <li>– Physical</li> <li>– Occupational</li> <li>– Speech</li> </ul> </li> <li>• Cognitive rehab</li> <li>• Behavior therapy</li> <li>• Enhanced care services (ECS) support and</li> <li>• Personal emergency response system (for members who live alone or who are alone for parts of the day and have no regular caregiver for extended periods of time)</li> </ul> <b>Certain limits apply:</b> <ul style="list-style-type: none"> <li>• Assistive services: maximum lifetime benefit of \$7,500 per member across waivers unless there is a precertification exception obtained</li> <li>• Benefit TBI therapies: maximum combined benefit of 780 hours per member per calendar year for behavioral, cognitive, occupational, physical and speech/language therapies</li> <li>• Home-delivered meals: two per member per calendar date</li> <li>• Medication reminder dispenser and installation: one installation per member per calendar year</li> <li>• Personal emergency response system and installation: two installations per year</li> <li>• Personal care services (PCS) for TBI waiver members: max. 10 hours per 24-hour time period</li> <li>• Enhanced care services (ECS) support period: min. of six hours in length; max. of 12 hours during any 24-hour period</li> </ul>



COVERED SERVICES	SERVICE DESCRIPTION	COVERAGE LIMITS
		<ul style="list-style-type: none"> <li>• Transitional living skills (not mandatory) – training may be received up to seven days a week: <ul style="list-style-type: none"> <li>– Max. of four hours (sixteen 15-minute units) a day</li> <li>– Min. of four hours (sixteen 15-minute units) per week</li> <li>– Max. of 3,120, 15-minute units per year</li> </ul> </li> </ul> <p><b>Financial Management Services (FMS):</b> For more details, see the FMS Appendix of this manual.</p> <p><b>Money Follows the Person Grant services for those in the TBI Waiver:</b></p> <ul style="list-style-type: none"> <li>• Transition service</li> <li>• Transition coordination service</li> <li>• Community bridge building</li> <li>• Community transition counseling and</li> <li>• Assistive services</li> </ul> <p>Precertification is required for all services.</p>
<b>FRAIL ELDERLY WAIVER</b>	<p>This benefit serves Kansas seniors who:</p> <ul style="list-style-type: none"> <li>• Are age 65 and older</li> <li>• Are in frail health</li> <li>• Receive Medicaid and</li> <li>• Qualify functionally to receive community-based services as an alternative to nursing facility care</li> </ul> <p>This program:</p> <ul style="list-style-type: none"> <li>• Promotes independence within the community</li> <li>• Offers placement in the most integrated environment</li> </ul>	<p><b>FE Waiver Services:</b> These services include:</p> <ul style="list-style-type: none"> <li>• Adult day care</li> <li>• Assistive technology (crisis exception only)</li> <li>• Personal care services (PCS)</li> <li>• Comprehensive support (crisis exception only) for members who: <ul style="list-style-type: none"> <li>– Live alone or</li> <li>– Do not have a regular caretaker for extended periods of time</li> </ul> </li> <li>• Home telehealth for members who: <ul style="list-style-type: none"> <li>– Have had two or more hospital stays, including emergency room visits, within the prior year related to one or more diseases or</li> <li>– Are using Money Follows the Person services to move from a nursing facility back into the community</li> </ul> </li> <li>• Medicine reminders for members who: <ul style="list-style-type: none"> <li>– Live alone or</li> <li>– Do not have a regular caretaker for extended periods of time</li> </ul> </li> <li>• Nurse evaluation visit for members who receive Level II personal care services (PCS) through: <ul style="list-style-type: none"> <li>– A home health agency</li> <li>– An assisted living facility</li> <li>– A residential health care facility or</li> <li>– Another licensed entity</li> </ul> </li> <li>• Oral health (crisis exception only)</li> <li>• Personal emergency response for members who: <ul style="list-style-type: none"> <li>– Live alone or are alone a significant</li> </ul> </li> </ul>

COVERED SERVICES	SERVICE DESCRIPTION	COVERAGE LIMITS
		<p>portion of the day in residential settings</p> <ul style="list-style-type: none"> <li>– Have no regular caretaker for extended periods of time and need routine supervision</li> <li>• Enhanced care services (ECS) support (crisis exception only)</li> <li>• Wellness monitoring</li> </ul> <p><b>Transferring from the PD Waiver to the FE Waiver program</b></p> <p><b>Before age 65</b></p> <p>A member on the PD waiver can:</p> <ul style="list-style-type: none"> <li>• Remain on the PD waiver or</li> <li>• Transfer to the FE waiver</li> </ul> <p><b>At age 65 or any time after age 65</b></p> <p>A member on the PD waiver can:</p> <ul style="list-style-type: none"> <li>• Transfer to the FE waiver*</li> </ul> <p>*A beneficiary can only transfer once</p> <p>Precertification is required for all services.</p> <p><b>Certain limits apply:</b></p> <ul style="list-style-type: none"> <li>• Adult day care: No more than two units of one to five hours of adult day care services will be covered over a 24-hour period.</li> <li>• Assistive Technology (AT) services: maximum lifetime benefit of \$7,500; AT services funded by other waiver programs are added into this maximum.</li> <li>• Home telehealth installation: max. of two installations per calendar year</li> <li>• Personal emergency response installation: max. of two installations per calendar year</li> <li>• Personal care services (PCS) (provider-directed) Level I, Level II and self-directed: max. of 48 units (12 hours) a day of any grouping of these services</li> <li>• Personal care services (PCS) (provider-directed) Level III: max. of 48 units (12 hours) per day</li> <li>• Comprehensive support: max. of 48 units (12 hours) a day during the beneficiary's normal waking hours; these services combined with other FE waiver services cannot exceed 24 hours a day</li> <li>• Nursing evaluation visit: one initial face-to-face evaluation visit by an RN per provider</li> <li>• Enhanced care services (EHS) support: min. of six hours in length; max. of 12 hours during any 24-hour period; this service combined with other FE waiver services cannot exceed 24 hours per day</li> </ul>

COVERED SERVICES	SERVICE DESCRIPTION	COVERAGE LIMITS
		<ul style="list-style-type: none"> <li>Wellness monitoring: limited to one face-to-face visit every 55 days or less often as decided by the targeted case manager</li> </ul> <p><b>Money Follows the Person Grant services for persons in the FE Waiver</b></p> <p>These services include:</p> <ul style="list-style-type: none"> <li>Transition service</li> <li>Transition coordination service</li> <li>Community bridge building</li> <li>Community transition counseling and</li> <li>Assistive services</li> </ul> <p><b>Financial Management Services (FMS)</b> For more details, see the FMS Appendix of this manual.</p> <p>All services require precertification.</p>
<b>SERIOUS EMOTIONAL DISTURBANCE WAIVER</b>	<p>This benefit serves youth who:</p> <ul style="list-style-type: none"> <li>Are eligible for SED waiver services</li> <li>Are at risk of admission to a state mental health hospital as stated in the approved waiver application</li> </ul> <p>The services offered through the SED waiver and other community mental health supports are vital in helping youth stay successful in their:</p> <ul style="list-style-type: none"> <li>Family home</li> <li>Community</li> </ul>	<p>Covered services include:</p> <ul style="list-style-type: none"> <li>Parent support and training</li> <li>Independent living/skills building</li> <li>Short-term respite care</li> <li>Wraparound facilitation, which is led by a community mental health provider who works with the member and the member's extended family to create an individual plan of care</li> <li>Professional resource family care</li> <li>Personal care services (PCS)</li> </ul> <p>Certain coverage limits apply. All SED waiver services require precertification.</p>
<b>INTELLECTUAL OR DEVELOPMENTAL DISABILITY WAIVER</b>	<p>The Intellectual and/or Developmental Disabilities (I/DD) Waiver program is designed to meet the needs of individuals ages five or older who would be institutionalized without these services. The variety of services described are designed to provide the least restrictive means for maintaining the overall physical and mental condition of those beneficiaries with the desire to live outside of an institution.</p> <p>Community Developmental Disabilities Organizations (CDDOs) are the "single point of entry" into this waiver. CDDO staff determines an individual's eligibility for the waiver.</p>	<p>Covered services include:</p> <ul style="list-style-type: none"> <li>Assistive Services</li> <li>Day Supports</li> <li>Medical Alert Rental</li> <li>Residential Supports</li> <li>Supported Employment</li> <li>Personal Care Services</li> <li>Wellness Monitoring</li> <li>Self-directed services, including: <ul style="list-style-type: none"> <li>Financial Management Services</li> <li>Overnight Respite Care</li> <li>Personal Care Services</li> <li>Enhanced Care Services (EHS) support</li> <li>Specialized Medical Care</li> </ul> </li> </ul> <p>See the sections Self-Directed Services and Financial Management Services to learn more.</p> <p>Note: Waiver services are not furnished to individuals who are inpatients of a hospital, nursing facility or ICF/IDD. Room, board, and transportation costs are excluded in the cost</p>

COVERED SERVICES	SERVICE DESCRIPTION	COVERAGE LIMITS
		<p>of all I/DD waiver services.</p> <p><b>Assistive Services</b> Assistive services are supports or items that meet a person's assessed needs by improving or promoting the person's:</p> <ul style="list-style-type: none"> <li>• Health</li> <li>• Independence</li> <li>• Productivity</li> <li>• Integration into the community</li> </ul> <p>These services must:</p> <ul style="list-style-type: none"> <li>• Increase the member's ability to live independently</li> <li>• Increase or enhance the member's productivity or</li> <li>• Improve the member's health and welfare</li> </ul> <p>Examples include but are not limited to wheelchair modifications, ramps, lifts, assistive technology, and accessibility-related modifications to bathroom and kitchens.</p> <p>Certain limits apply:</p> <ul style="list-style-type: none"> <li>• Purchase or rental of used assistive technology is limited to those items not covered by Amerigroup as a standard Medicaid or KAN Be Healthy benefit outside the waiver</li> <li>• Wheelchair modifications must be authorized by a registered physical therapist, identified as medically necessary (K.A.R. 30-5-58) by a physician, and identified on the member's plan of care.</li> <li>• Wheelchair modifications must be specific to the individual member's needs and not utilized as general agency equipment.</li> <li>• Van lifts purchased must meet any engineering and safety standards recognized by the Secretary of the U.S. Department of Transportation.</li> <li>• Van lifts can only be installed in family vehicles or vehicles owned or leased by the member. A van lift must not be installed in an agency vehicle unless an informed exception is made by Amerigroup.</li> <li>• Communication devices will only be purchased when recommended by a speech pathologist.</li> </ul>

COVERED SERVICES	SERVICE DESCRIPTION	COVERAGE LIMITS
		<ul style="list-style-type: none"> <li>• Communication devices can only be accessed after a member is no longer eligible to receive services through the local education system.</li> <li>• Communication devices are purchased for use by the member only not for use as agency equipment.</li> <li>• Home modifications must not increase the finished square footage of an existing structure.</li> <li>• Home modifications must not be accessed for new construction.</li> <li>• Home modifications must be used on property the member leases or owns or in the family home if still living there, but not on agency owned and operated property unless an informed exception is made by Amerigroup.</li> </ul> <p><b>Assistive Services Provider Requirements:</b></p> <ul style="list-style-type: none"> <li>• Agencies contracted to provide home modifications include contractors and/or agencies licensed by the county or city in which they work (if required by the county or city), and they must perform all work according to existing local building codes.</li> <li>• Assistive services require at least two bids from companies paid to either a CDDO or a qualified entity as determined by a CDDO and will not exceed the prior authorized purchase amount. The bids must be submitted and reviewed prior to the approval of the prior authorization.</li> <li>• All assistive services must have prior authorization. The member or responsible party must arrange for the purchase. Work must not be initiated until approval has been obtained through prior authorization.</li> </ul> <p><b>Note:</b> Responsible party is defined as the member's guardian or someone appointed by the member or guardian who is not a paid provider of services for the member.</p> <p><b>Day Supports</b></p> <ul style="list-style-type: none"> <li>• Day supports are available to IDD waiver members who are age 18 or older except in rare and extenuating circumstances in which Amerigroup will work with KDADS to determine</li> <li>• Supported employment must be provided away from the member's place</li> </ul>

COVERED SERVICES	SERVICE DESCRIPTION	COVERAGE LIMITS
		<p>of residence.</p> <ul style="list-style-type: none"> <li>Supported employment activities cannot be provided until the member has applied to the local Rehabilitation Services office. Supported employment activities will be covered under the I/DD waiver until Rehabilitation Services funding begins. Coverage of employment-related activities under the waiver will be suspended until the case is closed by Rehabilitation Services. If the member is determined ineligible for vocational training through Rehabilitation Services, then this service can be provided as a waiver service. Documentation of the determination must be maintained in the member's file.</li> <li>Day services providers may provide up to a maximum of eight hours (or 32 units) of service for a consumer on any given day, and cannot exceed 25 hours or 100 units per week. Maximum of 460 units per month. It is the desired outcome of DBHS/CSS that beneficiaries receiving Day Supports have the opportunity to receive such services consistent with their preferred lifestyle a minimum of 25 hours per week. DBHS/CSS understands each beneficiary has unique support needs, and this outcome can be met in a variety of ways.</li> <li>Beneficiaries must be out of their home a minimum of five hours per day or a total of 25 hours per week unless one of the following applies: <ul style="list-style-type: none"> <li>A person operates a home-based business</li> <li>A person is unable to be out of their home due to medical necessity or significant physical limitations related to frailty which a physician has provided current, written verification for the necessity to remain in the house</li> </ul> <p><b>Note:</b> Current is within the past 185 days and must be reviewed at least every 185 days thereafter.</p> </li> </ul> <p><b>Medical Alert</b> This monitoring system provides support to members who have a medical need that could be critical at any time. Examples of medical needs that may require this service are:</p> <ul style="list-style-type: none"> <li>Quadriplegia</li> </ul>

COVERED SERVICES	SERVICE DESCRIPTION	COVERAGE LIMITS
		<ul style="list-style-type: none"> <li>• Head injury</li> <li>• Diabetes that is hard to control</li> <li>• Severe heart conditions,</li> <li>• Severe convulsive disorders</li> <li>• Severe chronic obstructive pulmonary disease</li> </ul> <p><b>Certain limits apply:</b>  Medical alert can be maintained for a period of 30 days if the member is placed in a nursing home for a short stay Rental, but not purchase, of this unit is covered.  This service must be billed at a monthly rate.</p> <p>Examples of qualified providers of this service include, but are not limited to, agencies, hospitals, and emergency transportation service companies.</p> <p><b>Residential Supports</b>  This service provides help with gaining, keeping and/or improving skills related to activities of daily living such as:</p> <ul style="list-style-type: none"> <li>• Personal grooming and cleanliness</li> <li>• Bed making and household chores</li> <li>• Food preparation and</li> <li>• Social and adaptive skills needed to reside in a noninstitutional setting</li> </ul> <p><b>Certain limits apply:</b></p> <ul style="list-style-type: none"> <li>• Member receiving Residential Supports cannot also receive Supportive Home Care, Personal Care Services (as an alternative to Residential Supports), Overnight Respite, or Enhanced Care Services (EHS) Support.</li> <li>• Residential Supports cannot be provided in the member's family home. However, this service may be provided to a member in his or her own home or apartment as long as the community service provider is licensed by KDADS to provide this service.</li> <li>• Residential Supports for <i>children</i> cannot be provided in a home where more than two members funded with State or Medicaid money reside.</li> <li>• Children who receive Residential Supports with a nonrelated family must be at least 5 but no older than 21 years of age (eligibility ends on the 22nd birthday).</li> </ul>

COVERED SERVICES	SERVICE DESCRIPTION	COVERAGE LIMITS
		<ul style="list-style-type: none"> <li>Residential Supports is paid on a daily rate where one unit equals one day.</li> </ul> <p>Providers of Residential Supports for <i>children</i> must be affiliated with the CDDO for the area where they operate and be licensed by KDHE as a child-placing agency (K.A.R. 28-4-171).</p> <ul style="list-style-type: none"> <li>Providers of Residential Supports for <i>adults</i> must be a CDDO or affiliate that is licensed by KDADS to provide Residential Supports.</li> <li>Residential Supports for <i>adults</i> can serve no more than eight individuals in one home.</li> </ul> <p><b>Supported Employment</b> Supported employment is paid work in an integrated setting with ongoing support services for members with IDD An integrated work setting is:</p> <ul style="list-style-type: none"> <li>A job site similar to one for the general workforce</li> <li>Supported by any activity needed to maintain paid employment by persons with disabilities</li> </ul> <p>Activities designed to assist members in getting and keeping employment are:</p> <ul style="list-style-type: none"> <li>Personalized assessment</li> <li>Personalized job development and placement services</li> <li>On-the-job training</li> <li>Ongoing monitoring of individuals' performance</li> <li>Ongoing support services to help ensure a job is retained</li> </ul> <p><b>Certain limits apply:</b></p> <ul style="list-style-type: none"> <li>HCBS IDD supported employment is available to I/DD waiver members that are age 18 or older</li> <li>Members 18 to 21 years of age who are receiving a similar service supported by an Individual Education Plan cannot access this service.</li> <li>Supported Employment must be provided away from the member's place of residence.</li> <li>Supported employment services must not be provided until the member has applied to the local Rehabilitation Services office. The HCBS IDD waiver will fund supported employment activities until Rehabilitation Service's funding for the supported</li> </ul>



COVERED SERVICES	SERVICE DESCRIPTION	COVERAGE LIMITS
		<p>employment begins. Coverage under the waiver will be suspended until the case is closed by Rehabilitation Services.</p> <ul style="list-style-type: none"> <li>• If the member is determined ineligible for vocational training then this service can be provided as a waiver service. Documentation of this determination must be maintained in the member's file.</li> <li>• Case managers are responsible for ensuring that vocational rehabilitation services are NOT being duplicated for waiver members</li> </ul> <p><b>Supported Home Care</b>  These services are provided by an agency to help an individual who lives someone meeting the definition of family or is in one of these settings:</p> <ul style="list-style-type: none"> <li>• A child, age 5 to 21, who is in the custody of KDADs but is not living with immediate family</li> <li>• A child, age 15 or older, who lives with a person who is not immediate family and has not been appointed legal guardian or custodian</li> </ul> <p>Individual (one-to-one) services provide direct help with:</p> <ul style="list-style-type: none"> <li>• Daily living and personal adjustment</li> <li>• Personal Care Services (PCS)</li> <li>• Taking medicines usually taken on one's own</li> <li>• Accessing medical care</li> <li>• Supervision</li> <li>• Reporting changes in an individual's condition and needs</li> <li>• Extending therapy services</li> <li>• Walking and exercising</li> <li>• Household services needed for health care at home or performed along with help in daily living</li> </ul> <p><b>Certain limits apply:</b></p> <ul style="list-style-type: none"> <li>• Supportive Home Care (SHC) cannot be provided by a member's spouse or a parent of a member who is a minor child under age 18</li> <li>• SHC cannot be provided in a school setting or used for education in place of education-related services or used as transition services as stated in an individual's Individualized Education Plan (IEP). In order to verify that SHC services</li> </ul>

COVERED SERVICES	SERVICE DESCRIPTION	COVERAGE LIMITS
		<p>are not used as a substitute, an SHC Services Schedule (MR-10) must clearly define the division of educational services and SHC services. Educational services must be equal to or greater than the seven hours per day in which school is regularly in session. These hours do not have to be consecutive hours. The minimum number of hours required for kindergarten students is seven hours per day for those eligible for full-day kindergarten services and three-and-a-half hours per day for those eligible for half-day kindergarten</p> <ul style="list-style-type: none"> <li>• Members receiving Supportive Home Care cannot also receive Residential Supports</li> <li>• SHC services are limited to a maximum of an average eight hours per day in any given month. The services are only for the activities described previously unless sufficient rationale is provided for hours in excess of an average of eight hours per day. The absolute maximum allowable Supportive Home Care is an average of twelve hours per day in any given month.</li> <li>• A member can receive SHC services from more than one worker, but no more than one worker can be paid for services at any given time of day.</li> <li>• SHC services should not be used for lawn care, snow removal, shopping, ordinary housekeeping, or meal preparation (during the times when the person with whom the member lives would normally prepare a meal).</li> <li>• SHC retainer services can be billed up to a maximum of 14 days per calendar year, at a level consistent with the approved plan of care. These services are provided during the period of time when the member is an inpatient of a hospital, nursing facility, or ICF/IDD when the facility is billing Medicaid, Medicare, and/or private insurance. They are provided to assist members who self-direct their care with retaining their current care provider(s).</li> </ul> <p><b>Wellness Monitoring</b> Wellness monitoring requires a registered nurse (RN) to review a member's level of wellness. The RN decides if the member is:</p> <ul style="list-style-type: none"> <li>• Using medical health services properly, as</li> </ul>

COVERED SERVICES	SERVICE DESCRIPTION	COVERAGE LIMITS
		<p>recommended by the physician</p> <ul style="list-style-type: none"> <li>• Keeping a stable health status at home without frequent skilled nursing help</li> </ul> <p>Wellness monitoring includes checking or monitoring:</p> <ul style="list-style-type: none"> <li>• Orientation to surroundings</li> <li>• Skin characteristics</li> <li>• Edema</li> <li>• Personal hygiene</li> <li>• Blood pressure</li> <li>• Respiration</li> <li>• Pulse</li> <li>• Adjustments to medicine</li> </ul> <p><b>Certain limits apply:</b></p> <ul style="list-style-type: none"> <li>• The member lives in a noninstitutional setting.</li> <li>• The member is able to maintain independence with Wellness Monitoring visits no more than every 60 days.</li> <li>• Direct medical intervention is obtained through the appropriate medical provider and is NOT funded by this program.</li> <li>• Wellness Monitoring must be provided by a licensed RN in private employment or employed by a home health agency, local health department, CDDO, or affiliate.</li> <li>• The RN who provides Wellness Monitoring may also provide nursing care and supervise medical attendants.</li> <li>• Wellness Monitoring is not covered when provided within the same 60-day period as skilled nursing services provided by a home health agency.</li> <li>• Only one visit by an RN, per 60 days, is covered.</li> <li>• The Wellness Monitoring RN must provide the Targeted Case Manager with a brief written summary following each visit, indicating how the member is doing under the services currently provided. With the member's consent, this may also be forwarded to the primary care physician as appropriate.</li> <li>• Written documentation is required for services provided and billed to Amerigroup.</li> </ul> <p>Consideration will be made when documentation submitted with the claim indicates the medical need. This limitation will</p>

COVERED SERVICES	SERVICE DESCRIPTION	COVERAGE LIMITS
		<p>be monitored postpay.</p> <p><b>Targeted Case Management</b>  Targeted case management includes any or all of the following services:</p> <ul style="list-style-type: none"> <li>• Assessment – Assess an eligible member to determine service needs</li> <li>• Development of a specific support/care plan</li> <li>• Referral and related services to help a member obtain needed services</li> <li>• Monitoring and follow up</li> </ul> <p>Record keeping is the responsibilities rest with the TCM provider. KanCare requires written documentation of services provided and billed to Amerigroup.</p> <p><b>Certain limits apply:</b></p> <ul style="list-style-type: none"> <li>• The maximum allowable units per member are 240 units per calendar year.</li> <li>• Prior authorization must be requested prior to services being reimbursed for additional TCM units.</li> <li>• The case manager would assist the member in obtaining appropriate housing, getting utilities established and other activities necessary for the beneficiary to move from an institutional setting to a community-based setting.</li> <li>• TCM may be limited, at the choice for the person directing and controlling the services, to reviewing the services on a regular basis to ensure the member's needs are met, and the development of the person-centered support plan and plan of care.</li> <li>• TCM is not a covered benefit for the CHIP population.</li> </ul> <p><b>Provider Requirements:</b>  Entities licensed by the State and enrolled for TCM-I/DD with an affiliate agreement with the Community Development Disability Organization (CDDO) are the only allowable providers to be paid for TCM services.</p> <ul style="list-style-type: none"> <li>• Licensed TCM-I/DD providers are responsible for insuring individual case managers meet the requirements identified in Article 63</li> </ul> <p><b>Self-directed services:</b>  Following is a list of self-directed services;</p>

COVERED SERVICES	SERVICE DESCRIPTION	COVERAGE LIMITS
		<p>these services are:</p> <ul style="list-style-type: none"> <li>• Arranged for and purchased under the member's or responsible party's written approval</li> <li>• Performed by Personal Care Services (PCS)</li> </ul> <p>The member, or the responsible party who has the right to direct services, can decide to:</p> <ul style="list-style-type: none"> <li>• No longer self-direct services and</li> <li>• Receive prior approved waiver service without penalty</li> </ul> <p><b>Financial Management Services</b>  <i>See the section Financial Management Services to learn more.</i></p> <p><b>Overnight Respite Care</b>  Overnight respite is temporary care provided to a beneficiary to:</p> <ul style="list-style-type: none"> <li>• Relieve the beneficiary's family member who serves an unpaid primary caregiver</li> <li>• Allow family members to have periods of relief for vacations, holidays and scheduled time off</li> <li>• This service is available to waiver members who have a family member who serves as the primary caregiver who is not paid to provide any waiver service for the member.</li> <li>• Room and board costs are excluded in the cost of any I/DD waiver services <b>except</b> overnight <b>facility</b>-based respite.</li> <li>• Overnight Respite may only be provided to members living with a person immediately related to the member. Immediate family members are parents (including adoptive parents), grandparents, spouses, aunts, uncles, sisters, brothers, first cousins and any stepfamily relationships.</li> <li>• Overnight Respite cannot be provided by a member's spouse or by a parent of a member who is a minor child under 18 years of age.</li> <li>• Members receiving Overnight Respite cannot also receive Residential Supports or Personal Care Services (PCS) as an alternative to Residential Supports.</li> <li>• A member can receive Overnight Respite services from more than one worker, but no more than one worker can be paid for services at any given time of day. An</li> </ul>

COVERED SERVICES	SERVICE DESCRIPTION	COVERAGE LIMITS
		<p>Overnight Respite provider cannot be paid to provide services to more than one member at any given time of day.</p> <ul style="list-style-type: none"> <li>• Overnight Respite is limited to 60 days, per member, per calendar year.</li> <li>• Overnight Respite is billed on a daily rate, and the services provided must meet the member's support needs for a minimum of eight and maximum of 12 hours.</li> <li>• Overnight Respite care will be provided in the following locations and allow for staff to sleep: <ul style="list-style-type: none"> <li>— Member's home or place of residence</li> <li>— Licensed foster home</li> <li>— Facility approved by Amerigroup which is not a private residence</li> <li>— Licensed respite care facility/home</li> </ul> </li> </ul> <p><b>Overnight Respite Provider Requirements</b></p> <ul style="list-style-type: none"> <li>• Providers of Overnight Respite must be affiliated with the CDDO for the area where they operate.</li> <li>• Providers of overnight facility-based respite care for minor children must be licensed by KDADS or KDHE.</li> <li>• Adult respite providers must be licensed by KDADS Disability and Behavioral Health Services.</li> <li>• A self-direct option may be chosen for Overnight Respite by the member. If the member is not capable of providing self-direction, the member's guardian or someone acting on his or her behalf may choose.</li> </ul> <p><b>Personal Care Services (PCS)</b></p> <p>These services give members the help they need from Personal Care Services with tasks such as:</p> <ul style="list-style-type: none"> <li>• Activities of daily living like bathing and grooming</li> <li>• Independent activities of daily living like shopping, housecleaning and meal planning</li> <li>• Support services like community and recreational activities</li> </ul> <p>Personal Care Services is available to members who choose to <b>SELF-DIRECT</b> all or a portion of their services and live in one of the following types of settings:</p> <ul style="list-style-type: none"> <li>• A setting that would otherwise be considered an adult residential setting</li> </ul>

COVERED SERVICES	SERVICE DESCRIPTION	COVERAGE LIMITS
		<p>requiring services to be provided by an entity licensed by Disability and Behavioral Health Services – Community Supports and Services (DBHS-CSS)</p> <ul style="list-style-type: none"> <li>• A setting where the person lives with someone meeting the definition of family  <b>Note:</b> Family is defined as any person immediately related to the beneficiary. Immediate-related family members are a parent (including an adoptive parent), grandparent, spouse, aunt, uncle, sister, brother, first cousin, and anyone with a step-family relationship.</li> <li>• A setting where a child, 5 to 21 years of age, is in the custody of KDADS but not living with someone meeting the definition of family</li> <li>• A setting in which a child, 15 years of age or older, resides with a person who does not meet the definition of family and who has not been appointed the legal guardian or custodian</li> </ul> <p><b>Certain limits apply:</b></p> <ul style="list-style-type: none"> <li>• All Personal Care Services (PCS) must be arranged for, and purchased under, the member's or responsible party's written authority and paid through an enrolled Financial Management Services (FMS) provider consistent with and not exceeding the member's plan of care. Members are permitted to choose qualified direct support workers who have passed background checks that ensure compliance with KAR 30-63-28(f).</li> <li>• Members who were receiving agency-directed services and at some point chose to self-direct their services and then determined that they no longer wanted to self-direct their Personal Care Services (PCS) will have the opportunity to receive their previously approved waiver services, without penalty.</li> <li>• A direct support worker cannot perform any duties for the member that would otherwise be consistent with Supported Employment.</li> <li>• The expectation is that waiver members who need assistance with daily living tasks should rely on informal/natural supporters for this assistance unless there are extenuating circumstances that have been documented in the person-centered support plan. For example, the</li> </ul>

COVERED SERVICES	SERVICE DESCRIPTION	COVERAGE LIMITS
		<p>role of the direct support worker is defined as a person who is teaching the member how to perform a skill. In accordance with this expectation, Personal Care Services (PCS) should not be used for lawn care, snow removal, shopping, ordinary housekeeping, and meal preparation (during the times when the person with whom the member lives would normally prepare the meal).</p> <ul style="list-style-type: none"> <li>• Personal Care Services (PCS) can be retained up to a maximum of 14 days per calendar year, at a level consistent with the approved plan of care. These services are retained during times when the beneficiary is an inpatient of a hospital, nursing facility, or ICF/IDD and the facility is billing Medicaid, Medicare, and/or private insurance. This is provided to assist members who self-direct their care with retaining their current direct support worker(s).</li> <li>• Members receiving Residential Supports <b>cannot</b> also receive Personal Care Services (PCS) as an alternative for the same residential supports or any of the other family/individual supports. This does not prevent the conversion of Day Supports to Personal Care Services (PCS).</li> <li>• Members receiving Day Supports <b>cannot</b> also receive Personal Assistant Services as an alternative for the same day supports. This does not prevent the conversion of Residential Supports to Personal Assistant Services.</li> <li>• A member can have several direct support workers providing him or her care on a variety of days at a variety of times, but a person <b>cannot</b> have more than one direct support worker providing care at any given time</li> <li>• In addition, Amerigroup will not approve services for which it is determined that the provision of Personal Care Services (PCS) would be a duplication of services already approved on the plan of care.</li> <li>• Personal Care Services (PCS) are limited to a maximum of an average eight hours per day in any given month. The services are only for the activities described previously unless sufficient rationale is provided for hours in excess of an average of eight hours per day. The</li> </ul>



COVERED SERVICES	SERVICE DESCRIPTION	COVERAGE LIMITS
		<p>absolute maximum allowable Personal Care Services (PCS) is an average of twelve hours per day in any given month.</p> <p><b>Enhanced Care Services (EHS) Support</b>  This service gives overnight assistance to members living with family or members who are not living with family and choose to self-direct service. An Enhanced Care Services (ECS) Support direct support worker is available to:</p> <ul style="list-style-type: none"> <li>• Call a doctor or hospital</li> <li>• Provide help if an emergency occurs</li> <li>• Turn and reposition the member</li> <li>• Assist with peri-care and/or toileting</li> <li>• Remind the member of nighttime medicines</li> <li>• Administer medicines when needed</li> <li>• Are eligible for the Medicaid program through certain waiver requirements relating to parental income and</li> </ul> <p><b>Certain limits apply:</b></p> <ul style="list-style-type: none"> <li>• Enhanced Care Services (ECS) Support cannot be provided by the member's spouse or by a parent of a member less than 18 years of age.</li> <li>• Enhanced Care Services (ECS) Support <b>cannot</b> be provided to members receiving Residential Supports.</li> <li>• Enhanced Care Services (ECS) Support is limited to members unable to be alone at night due to anticipated medical problems.</li> <li>• The period of service for Enhanced Care Services (ECS) Support is a minimum of 8 hours and cannot exceed 12 hours.</li> <li>• The self-direct option may be chosen for Enhanced Care Services (ECS) Support by the member. If the member is incapable of providing self-direction, his or her guardian, parent, or other person acting on his or her behalf may choose.</li> <li>• A member can receive Enhanced Care Services (ECS) Support from more than one worker, but no more than one worker can be paid for services at any given time of day. A Enhanced Care Services (ECS) Support provider cannot be paid to provide services to more than one member at any given time of day.</li> <li>• A statement of <b>medical necessity</b>, signed by a physician, must be on</li> </ul>

COVERED SERVICES	SERVICE DESCRIPTION	COVERAGE LIMITS
		<p>record.</p> <p><b>Specialized Medical Care</b>  This service provides long-term nursing support for members who are medically fragile and depend on certain equipment/tools for support. The level of care must:</p> <ul style="list-style-type: none"> <li>• Provide medical support for a member needing ongoing, daily care that would otherwise require the member to be in the hospital</li> <li>• Meet the member's needs to ensure he or she can live outside of a hospital or ICF/IDD</li> <li>• Are eligible for the Medicaid program through certain waiver requirements relating to parental income and</li> </ul> <p>A provider of Specialized Medical Care must be:</p> <ul style="list-style-type: none"> <li>• A registered nurse (RN)</li> <li>• A licensed practical nurse (LPN) under the supervision of an RN</li> <li>• Another entity designated by the Kansas Department of Children and Families and KDADs</li> </ul> <p><b>Certain limits apply:</b></p> <ul style="list-style-type: none"> <li>• Members of Specialized Medical Care cannot also receive Residential Supports or Personal Care Services (PCS) as an alternative to Residential Supports.</li> <li>• Specialized medical care services may not be provided by a member's spouse or by a parent of a member who is a minor child under 18 years of age.</li> <li>• Specialized medical care services are limited to a maximum of an average of 12 hours per day or 372 hours (1488 units) per month. One unit is equal to 15 minutes.</li> <li>• A member can receive specialized medical care services from more than one worker, but no more than one worker can be paid for services at any given time of day. A Specialized Medical Care provider cannot be paid to provide services to more than one member at any given time of day.</li> </ul>

### 4.3 Presumptive Eligibility

A Presumptive Eligibility (PE) program is available for members through KanCare. Qualified Entities (QE) make an on-the-spot determination that the member should be eligible for Medicaid and issue a PE letter that will temporarily serve as their proof of eligibility. This letter can be used for a period of seven days to receive medical services while paperwork is completed to provide full eligibility under the KanCare program. A Qualified Entity is a hospital or clinic approved by the state to determine any individual's eligibility. Following the state's guidelines, short-term coverage for a duration approved by Kansas Department of Health and Environment (KDHE) can be issued.

Once submitted, the PE application is processed within a few days at the KanCare clearinghouse. The application can be processed within as little as one day, but generally within four to five business days.

A PE patient can receive care from any provider and once a member's temporary eligibility expires, you should check KMAP to verify the member has been made eligible for KanCare and render services as applicable if the date on the PE letter has expired.

Once the member is enrolled with Amerigroup, a permanent ID card is mailed within two days of receipt of the member's information on our 834-enrollment file.

### 4.4 Amerigroup Value-added Services

Amerigroup covers extra benefits that eligible members cannot get from fee-for-service Medicaid. These extra benefits are called value-added services. Certain rules and restrictions may apply.

Members receive detailed information about how to access these services in their member handbooks, on [www.myamergroup.com/KS](http://www.myamergroup.com/KS) or by calling our Member Services team for more information.

If you have questions about how to help a member with these services, call our Provider Services team for assistance.

<b>Amerigroup Value-added Services</b>	<b>For All KanCare Members</b>	<b>For SSI or Waiver Members Only</b>
Dental care for people 21 and over: <ul style="list-style-type: none"><li>• Two free cleanings and scalings per year</li></ul>	X	
Members can earn between \$10 to \$25 on their Healthy Rewards cards each time they get certain health checkups and screenings. Members can use these cards at participating Dollar General or Family Dollar stores to purchase health and wellness items, such as over-the-counter medicines, baby care, hygiene and home health products.	X	
We help certain members get free cell phones through SafeLink and up to 350 minutes of service each month plus: <ul style="list-style-type: none"><li>• 200 bonus minutes plus unlimited text messaging</li><li>• Wellness texts and reminders to renew your benefits on time</li><li>• Unlimited minutes to call our Member Services line</li></ul>	X	
Taking Care of Baby and Me® prenatal and postnatal program with health resources, coaching, a special self-care book and more debit card credits.	X	
Free programs to help adults:	X	

<b>Amerigroup Value-added Services</b>	<b>For All KanCare Members</b>	<b>For SSI or Waiver Members Only</b>
<ul style="list-style-type: none"> <li>• Stop smoking</li> <li>• Lose weight</li> </ul> And, free healthy living coaching for preteens is available.		
<ul style="list-style-type: none"> <li>• Extra over-the-counter medicines through mail order for all waiver groups and members receiving SSI.</li> <li>• \$120 annually (\$10 monthly) towards the purchase of over-the-counter products.</li> </ul>		X
Free rides to community health events and free caregiver transportation to doctor visits for all waiver groups and members receiving SSI.		X
Free in-home pest control for all waiver groups and members receiving SSI (excludes members residing in ICF/IDD, assisted living and nursing facilities, group homes, or similar settings) not to exceed four treatments or \$500.		X
Respite care for caregivers of Frail Elderly waiver members and extra respite care for members of Autism, Developmental Disability waiver groups (excludes members living alone or residing in ICF/IDD, assisted living and nursing facilities, group homes or similar settings).		X
Up to \$100 in hypoallergenic bedding for certain members with asthma or allergies with a confirmed diagnosis.	X	
Personal Care Services (PCS) for I/DD waiver members		x

#### **4.5 Blood Lead Screenings**

You should use the Mandatory Blood Lead Screening Questionnaire available at <https://www.kmap-state-ks.us/public/forms.asp> and clinical judgment when screening for lead toxicity. However, in order to comply with federal government requirements, you must perform a blood lead test at 12 months and 24 months of age to determine lead exposure and toxicity. You should also give blood screening lead tests to children older than 24 months up to 72 months if you have no past record of a test. You can find blood lead risk forms at [providers.amerigroup.com/KS](http://providers.amerigroup.com/KS).

#### **4.6 Financial Management Services**

Financial Management Services (FMS) are provided for KanCare members who are aging or disabled. According to Kansas state law (K.S.A. 39-7,100), members have the right to self-direct (i.e., make decisions about, direct the provisions of and control the Personal Care Services (PCS) received, including but not limited to selecting, training, managing, paying and dismissing of a direct support worker). The member or his or her representative has decision-making authority over certain services and takes direct responsibility to manage these services with the assistance of a system of available supports. FMS is included in these supports.

For more information, we suggest visiting the following websites:

[www.selfdirect.ks.gov/Pages/default.aspx](http://www.selfdirect.ks.gov/Pages/default.aspx)

[www.selfdirect.ks.gov/CaseManagersAndProviders/Pages/FMS\\_Facts.aspx](http://www.selfdirect.ks.gov/CaseManagersAndProviders/Pages/FMS_Facts.aspx)

#### **Eligibility**

FMS is available to members who reside in their own private residences or private homes of family members whom the state has determined are eligible for specific waiver programs and have chosen to self-direct some or all of their services. The member or his or her representative has the right to choose this model and from

qualified available FMS providers. The administrative functions of the FMS provider are reimbursed as waiver services.

#### **4.7 Immunizations**

If you are authorized to prescribe vaccines, we strongly encourage you to enroll in the Vaccines for Children (VFC) program administered by KDHE. Once enrolled, you may request state-supplied vaccines for members through the age of 18 in accordance with the current American Committee on Immunization Practices schedule. You must report all immunizations of children up to age 2 to Kansas WebIZ (the Kansas Web Immunization Registry). If you do not have the capability to meet these requirements, we can help you.

We do not cover any immunizations, biological products or other products that are available free of charge from Kansas WebIZ.

Our members can self-refer to any qualified provider in or out of our network.

We only cover the administration fee for members ages 18 and younger. Since VFC only covers serum for children ages 18 and younger, Amerigroup pays for these vaccines for our 19- and 20-year-old members.

#### **4.8 Medically Necessary Services**

Medically necessary is a term used to describe a requested service that is reasonably calculated to prevent, diagnose, correct, cure, alleviate or prevent worsening of conditions in a patient that:

- Endanger life
- Cause suffering or pain
- Result in an illness or infirmity
- Threaten to cause or aggravate a handicap
- Cause physical deformity or malfunction

There is no other equally effective, more conservative or substantially less costly course of treatment available or suitable for the client requesting the service. For the purposes of this section, course of treatment may include mere observation or, where appropriate, no medical treatment at all. The amount and duration of services that are medically necessary depend on each member's medical condition.

Amerigroup does not specifically reward practitioners or other individuals for issuing denials of coverage or care, and financial incentives for utilization management decision-makers do not encourage decisions that result in underutilization.

A covered service is considered to be medically necessary if it is recommended by the member's treating provider and the Amerigroup medical director or provider designee and if all of the following conditions are met:

- The purpose of the service, supply or intervention is to treat a medical condition.
- It is the most appropriate level of service, supply or intervention considering the potential benefits and harm to the patient.
- The level of service, supply or intervention is known to be effective in improving health outcomes.
- The level of service, supply or intervention recommended for the condition is cost-effective compared to alternative interventions, including no intervention.
- For new interventions, effectiveness is determined by scientific evidence; for existing interventions, effectiveness is determined first by scientific evidence, then by professional standards, then by expert opinion.

Amerigroup is responsible for covering medically necessary services related to:

- Prevention, diagnosis and treatment of health impairments
- Achievement of age-appropriate growth and development
- The attainment, maintenance or regaining of functional capacity

A health intervention is an otherwise covered category of service, is not specifically excluded from coverage and is medically necessary, according to all of the following criteria:

- “Authority.” The health intervention is recommended by the treating physician and is determined to be necessary by the secretary or the secretary’s designee.
- “Purpose.” The health intervention has the purpose of treating a medical condition.
- “Scope.” The health intervention provides the most appropriate supply or level of service, considering potential benefits and harms to the patient.
- “Evidence.” The health intervention is known to be effective in improving health outcomes. For new interventions, effectiveness shall be determined by scientific evidence as provided herein. For existing interventions, effectiveness shall be determined as provided in paragraph I.
- “Value.” The health intervention is cost-effective for this condition compared to alternative interventions, including no intervention. “Cost-effective” shall not necessarily be construed to mean lowest price. An intervention may be medically indicated and yet not be a covered benefit or meet this regulation’s definition of medical necessity.
- Interventions that do not meet this regulation’s definition of medical necessity may be covered at the choice of the secretary or the secretary’s designee. An intervention shall be considered cost effective if the benefits and harms relative to costs represent an economically efficient use of resources for patients with this condition. In the application of this criterion to an individual case, the characteristics of the individual patient shall be determinative.
- The following definitions shall apply to these terms only as they are used above.
  - “Effective” means that the intervention can be reasonably expected to produce the intended results and to have expected benefits that outweigh potential harmful effects.
  - “Health intervention” means an item or service delivered or undertaken primarily to treat a medical condition or to maintain or restore functional ability. For this regulation’s definition of medical necessity, a health intervention shall be determined not only by the intervention itself, but also by the medical condition and patient indications for which it is being applied.
  - “Health outcomes” means treatment results that affect health status as measured by the length or quality of a person’s life.
  - “Medical condition” means a disease, illness, injury, genetic or congenital defect, pregnancy, or a biological or psychological condition that lies outside the range of normal, age-appropriate human variation.
  - “New intervention” means an intervention that is not yet in widespread use for the medical condition and patient indications under consideration.
  - “Scientific evidence” means controlled clinical trials that either directly or indirectly demonstrate the effect of the intervention on health outcomes. However, if controlled clinical trials are not available, observational studies that demonstrate a causal relationship between the intervention and health outcomes may be used. Partially controlled observational studies and uncontrolled clinical series may be considered to be suggestive, but shall not by themselves be considered to demonstrate a causal relationship unless the magnitude of the effect observed exceeds anything that could be explained either by the natural history of the medical condition or potential experimental biases.
  - “State designee” means a person or persons designated by the state to assist in the medical necessity decision-making process.
  - “Treat” means to prevent, diagnose, detect or palliate a medical condition.
  - “Treating physician” means a physician who has personally evaluated the patient.

- h. Each new intervention for which clinical trials have not been conducted because of epidemiological reasons, including rare or new diseases or orphan populations, shall be evaluated on the basis of professional standards of care or expert opinion as described below in paragraph I.
- i. The scientific evidence for each existing intervention shall be considered first and, to the greatest extent possible, shall be the basis for determinations of medical necessity. If no scientific evidence is available, professional standards of care shall be considered. If professional standards of care do not exist, or are outdated or contradictory, decisions about existing interventions shall be based on expert opinion. Coverage of existing interventions shall not be denied solely on the basis that there is an absence of conclusive scientific evidence. Existing interventions may be deemed to meet this regulation's definition of medical necessity in the absence of scientific evidence if there is a strong consensus of effectiveness and benefit expressed through up-to-date and consistent professional standards of care or, in the absence of those standards, convincing expert opinion.
- j. Amerigroup is responsible for covering services related to the following:
  - 1. The prevention, diagnosis and treatment of health impairments
  - 2. The ability to achieve age-appropriate growth and development
  - 3. The ability to attain, maintain or regain functional capacity

## **4.9 Pharmacy Services**

### **Covered Drugs**

The Amerigroup Pharmacy Program utilizes the Kansas Medical Assistance Program (KMAP) Fee-for-Service formulary and Preferred Drug List (PDL).

### **Kansas Formulary**

The Kansas formulary is a complete list of covered outpatient drugs billed using NDCs under the pharmacy benefit. A subset of the Kansas formulary is the Kansas PDL.

The Amerigroup pharmacy benefit provides coverage for medically necessary medications from any licensed prescriber for legend and non-legend medications that appear in accordance with the KMAP's latest revision of the Kansas formulary and PDL for Medicaid and CHIP members. For coverage information, please refer to the KMAP website [NDC search tool](#).

*Note: Use the KMAP Secure Web portal to verify the member's benefit plan. When using the NDC Search Tool, use either TXIX or the ADAP benefit plan to query general KanCare coverage. Pricing information and limitations on this website may not be applicable to the KanCare health plans. Information provided does not guarantee coverage or payment, as these are based on the beneficiary's eligibility or other restrictions.*

### **PDL**

KMAP has created a PDL to promote clinically appropriate utilization of pharmaceuticals in a cost-effective manner without compromising the quality of care. The Kansas Medicaid PDL was authorized by K.S.A. 39-7,121a, allowing KMAP to develop a PDL based on safety, effectiveness and clinical outcomes. If these factors indicate no therapeutic advantage among the drugs being considered in the same drug class, KMAP considers the net economic impact (lowest net cost to the state) of such drugs when recommending drugs for inclusion in the Medicaid PDL. The statute states that "...drugs which do not have a significant, clinically meaningful therapeutic advantage in terms of safety, effectiveness or clinical outcomes may be excluded from the preferred drug formulary and be subject to prior authorization in accordance with state and federal laws."

The PDL Committee, composed of practicing physicians and pharmacists, ensures extensive clinical review of drug products takes place. The PDL Committee's review and recommendations are based on evidence-based clinical information, not cost. Evidence-based medicine means providing treatments that have been shown to be

effective, beneficial and have high value and not providing treatments that have been shown to be ineffective, harmful or have poor value. All PDL Committee meetings are open to the public, and drug manufacturers may make presentations before committee action is taken.

After KMAP decides which drugs in a specific drug class will be preferred and nonpreferred, preliminary recommendations for prior authorization criteria are developed for the nonpreferred drugs and taken to the Kansas Drug Utilization Review (DUR) Board for review and approval in accordance with K.S.A. 39-7,118. The drugs that are placed on prior authorization are documented in KS policy before the prior authorization is effective.

Only drugs that are part of the listed therapeutic classes are affected by the PDL. Therapeutic classes not listed are not part of the PDL and will continue to be covered as they always have for the Kansas Medical Assistance Pharmacy Program.

After the PDL Committee and DUR Board recommendations are made and published in KS policy, then new prescriptions for the nonpreferred drugs will require prior authorization. As other therapeutic drug classes are evaluated by the PDL Committee and the DUR Board, Amerigroup will publish this information to providers.

### **Dispensing Pharmacy Responsibilities**

Pharmacy providers are responsible for the following, including but not limited to:

- Filling prescriptions in accordance with K.S.A. 39-7,121a
- Filling prescriptions in accordance with the benefit design
- Coordinating with licensed prescribers
- Ensuring members receive all medications for which they are eligible
- Coordinating benefits when members also receive Medicare Part D services or other insurance benefits
- Providing emergency supplies of prescribed medications any time prior authorizations are not available if the prescribing providers cannot be reached or are unable to request prior authorizations and when prescriptions must be filled without delay for medical conditions; these supplies will be provided for as long as is sufficient to bridge the time until an authorization determination is made

Amerigroup has contracted with Express Scripts to process prescription drug claims using a computerized Point-Of-Sale (POS) system. This system gives participating pharmacies online, real-time access to member eligibility, drug coverage (including prior authorization requirements), prescription limitations, pricing and payment information, and prospective drug utilization review.

### **Obtaining Prior Authorization**

Some drugs may require clinical and/or PDL prior authorizations. All pharmacy prior authorization criterion is approved by the Kansas Drug Utilization Review (DUR) Board in accordance with K.S.A. 39-7,118. Providers are strongly encouraged to write prescriptions for preferred products as listed on the PDL. If, for medical reasons, a member cannot use a preferred product, providers are required to contact Express Scripts to obtain prior authorization (PA). Other drugs may require prior authorization due to clinical reasons. **Providers may call the Express Scripts PA help desk at 1-855-201-7170 or fax to 1-800-601-4829. They may also sign up for electronic PA at <https://express-scripts.covermymeds.com/> or <https://www.express-path.com/>.**

Be prepared to provide relevant clinical information regarding the member's need to use a nonpreferred product or a medication requiring prior authorization. Decisions are made on medical necessity and are determined according to certain established medical criteria.



Nonpreferred drug PA criteria:

A provider must demonstrate at least one of the following:

- Medical intolerance to a preferred drug (provide clinical symptoms)
- Inadequate response to a preferred drug
- Absence of appropriate formulation or indication of the drug (specify)

Approved PDL PAs are valid for one year. Clinical PA approval length may vary depending on the criteria. Providers will be notified via fax of the approval or denial of the PA.

A 72-hour emergency supply of a prescribed drug must be provided when a medication is needed without delay and PA is not available. This applies to all drugs requiring prior authorization, either because they are nonpreferred drugs on the PDL or because they are subject to clinical edits.

The 72-hour emergency supply should be dispensed anytime a PA cannot be resolved within 24 hours for a medication on the formulary that is appropriate for the member's medical condition. If the prescribing provider cannot be reached or is unable to request a PA, the pharmacy should submit an emergency 72-hour prescription.

A pharmacy may dispense a product packaged in dosage form that is fixed and unbreakable (e.g., an albuterol inhaler) as a 72-hour emergency supply.

### **Prescription Limits**

Most prescription claims are limited to a maximum 31-day supply. There is a mandatory 90-day supply requirement for maintenance medications. Prescription claims for maintenance medications as defined by KDHE shall be dispensed in quantities of 90-day supply after an initial therapy period. Maintenance medications may be dispensed in quantities less than 90-day supply until a total of 90-day supply has been dispensed in the last 365 days. Prescription claims submitted after the initial therapy period for quantities less than 90-day supply will deny at the pharmacy. All prescriptions must be filled in accordance with Kansas Pharmacy Law.

Drugs used to treat mental illnesses such as schizophrenia, depression or bipolar disorder, may be subject to drug optimization quantity limits or may require prior authorization.

Some drugs qualify for our dose optimization or consolidation program. This program is designed to increase patient adherence with drug therapies. This could potentially decrease the number of tablets or capsules members have to take per day. The goal is to replace multiple doses of lower strength medications where clinically appropriate with a single dose of a higher-strength medication. Pharmacy claims exceeding the units per day limit will deny.

Please work with your Amerigroup members to transition them to the optimized dose. If you determine preferred dosing alternatives are not clinically appropriate for specific members, you will need to obtain prior authorization.

### **Excluded Drugs**

The following are excluded from the pharmacy benefit:

- In accordance with Section 1927 of the Social Security Act, 42 U.S.C.A. §1396r-8, coverage is excluded for any drug marketed by a drug company (or labeler) that does not participate in the federal drug rebate program
- Drug products that are classified as less-than-effective by the Food and Drug Administration (FDA) Drug Efficacy Study Implementation (DESI)

- Drugs excluded from coverage following Section 1927 of the Social Security Act, 42 U.S.C.A. §1396r-8 such as:
  - Drugs used for cosmetic reasons or hair growth
  - Drugs used for experimental or investigational indication
  - Infertility medications
  - Erectile dysfunction drugs to treat impotence
- Nonlegend drugs other than those listed above or specifically listed under covered nonlegend drugs
- Pharmaceutical products prescribed by any providers related to services provided under separate contracts with the KDHE

### **Medication Therapy Management**

Outcomes MTM administers our Medication Therapy Management (MTM) program in which members who are taking five or more medications and have two or more chronic conditions are offered opportunities to speak directly to Kansas-licensed pharmacist about their medication use. The pharmacist will perform a complete review of the member's medication use and make recommendations for improving medication safety, effectiveness and reducing costs. These recommendations will be shared with the member's Primary Care Provider (PCP).

MTM programs have been shown to be effective at improving health care quality while reducing medical and/or pharmacy costs. For more information about our MTM program, please visit our provider website.

#### **4.10 Taking Care of Baby and Me® Pregnancy Support Program**

Taking Care of Baby and Me® is a proactive case management program for mothers and their newborns. It identifies pregnant women as early in their pregnancies as possible through review of state enrollment files, claims data, lab reports, hospital census reports, and provider and self-referrals. Once pregnant members are identified, we act quickly to assess obstetrical risk and ensure appropriate levels of care and case management services to mitigate risk.

Experienced case managers work with members and providers to establish a care plan for our highest risk pregnant members. Case managers collaborate with community agencies to ensure mothers have access to necessary services, including transportation, WIC, home-visitor programs, breastfeeding support and counseling.

For parents with infants admitted to the NICU, we offer the You and Your Baby in the NICU program. Parents receive counseling and support to be involved in the care of their babies, visit the NICU, interact with hospital-care providers and prepare for discharge. Parents are provided with an education resource outlining successful strategies they may deploy to collaborate with the care team.

We also work with the My Advocate™ program (formerly known as Warm Health™) to improve our members' health outcomes. The My Advocate service promotes regular doctor visits, compliance with prescription medications and general health education through automated telephone outreach, text messaging or smartphone applications. Eligible members receive regular calls with tailored content. The frequency of communication is based on each member's health history and risks. Topics include:

- OB high-risk screening
- Maternal and child health support
- Prenatal care
- Postpartum care
- Well-baby care

Don't be surprised if your patients tell you MaryBeth or Lucy (the English and Spanish voice talents) reminded them to make their appointment. Take it as a sign that we are doing our job. We hope you will encourage your

patients to listen to their My Advocate calls. You will see the results in the form of a better-educated, more communicative patient population.

If you would like more information on the My Advocate educational program or our high-risk OB case management program, please call 1-800-454-3730. Also, visit [www.myadvocatehelps.com](http://www.myadvocatehelps.com) to learn more.

## 5. PRECERTIFICATION AND NOTIFICATION PROCESSES

Referrals to in-network specialists are not required. However, some specialty services require precertification, sometimes referred to as prior authorization (PA), within certain Kansas reference documents, as specified below. We encourage members to consult with their Primary Care Providers (PCPs) prior to accessing nonemergency specialty services. The two processes are defined below.

**Precertification** is defined as the **prospective** process whereby licensed clinical associates apply designated criteria sets against the intensity of services to be rendered, a member's severity of illness, medical history and previous treatment to determine the medical necessity and appropriateness of a given coverage request. Prospective means the coverage request occurred prior to the service being provided.

**Prior notification** means notifying Amerigroup of services to be given to the member **before** the member receives treatment or services. This must be done via our provider website, fax or phone. There is no review against medical necessity criteria. However, member eligibility and provider status (network and non-network) are verified. In some instances, providers should notify Amerigroup within 24 hours of the visit.

For cases where the member is made retroactively eligible for KanCare, a waiver program or a nursing facility, please contact Amerigroup on the next business day to obtain retro-authorization for the applicable services.

Inpatient admission requests are subject to further review, including length of stay and level of care reviews.

Honored requests are not a guarantee of payment. Claims payment is subject to eligibility, benefits and medical necessity review at the time of service.

### 5.1 Confidentiality of Information During the Process

We maintain procedures to help ensure patients' Protected Health Information (PHI) is kept confidential. PHI is shared only with those individuals who need access to it to conduct some or all of the following functions:

- Utilization management
- Case management
- Disease Management Centralized Care Unit Discharge planning
- Quality management
- Claims payment
- Pharmacy

### 5.2 Precertification and Notification Guidelines

24/7 precertification and notification:

- Online at [providers.amerigroup.com/KS](https://providers.amerigroup.com/KS)
- By fax to 1-800-964-3627
- By call to 1-800-454-3730

24/7 pharmacy precertification and notification:

- Online at [www.express-scripts.com](https://www.express-scripts.com)
- By fax to 1-800-601-4829
- By call to 1-855-201-7170

Medical Injectable precertification and notification

- By fax to 1-855-363-0728

- By call to 1-800-454-3730

Please provide the following information with your requests:

- Member or Medicaid ID
- Member's Social Security number if available
- Member's date of birth
- Legible name of referring provider
- Legible name of person referred to provider
- Number of visits/services
- Date(s) of service
- Diagnosis
- CPT/HCPCS codes
- Clinical information

<b>Behavioral (Mental) Health/Substance Use Disorder Services</b>	<p>Precertification is not required for basic behavioral health services provided in a PCP or medical office.</p> <p>Inpatient SUD, detox and behavioral health services including Psychiatric Residential Treatment Facilities (PRTF) services require precertification.</p> <p>For information on precertification requirements for behavioral health specialty services, please see Appendix B.</p>
<b>Cardiac Rehabilitation</b>	Precertification is required for all services.
<b>Chemotherapy</b>	<ul style="list-style-type: none"> <li>• Precertification is not required for procedures performed in the following outpatient settings: office, outpatient hospital or ambulatory surgery center.</li> <li>• Precertification is required for inpatient chemotherapy as part of the inpatient admission.</li> </ul> <p>To check the coverage and precertification requirement status for oncology drugs and adjunctive agents, please refer to the Precertification Lookup tool on our provider self-service site.</p>
<b>Circumcision</b>	Precertification is not required.
<b>Dental Services</b>	Precertification may be required for dentists contracted with Scion Dental. Please call Scion Dental at 1-855-812-9206.
<b>Dermatology</b>	<ul style="list-style-type: none"> <li>• Precertification is not required for a network provider for E&amp;M, testing or procedures.</li> <li>• Cosmetic services or services related to previous cosmetic procedures are not covered. For code-specific requirements, visit our provider website.</li> </ul>
<b>Diagnostic Testing</b>	<ul style="list-style-type: none"> <li>• Precertification is not required for routine diagnostic testing.</li> <li>• Precertification is required for MRA, MRI, CAT scan, nuclear cardiology and video EEG.</li> </ul> <p>AIM Specialty Health® (AIM) manages preauthorization for computer tomography (CT/CTA) scans, nuclear cardiology, stress echocardiography (SE), echocardiogram (echo), resting transthoracic echocardiography (TTE), magnetic resonance (MRI/MRA) and transesophageal echocardiography (TEE). They can be contacted at 1-800-714-0040 or <a href="http://www.aimspecialtyhealth.com">http://www.aimspecialtyhealth.com</a>.</p>
<b>Durable Medical Equipment (DME)</b>	<p>Precertification is not required for:</p> <ul style="list-style-type: none"> <li>• Glucometers and nebulizers</li> <li>• Dialysis and ERSD equipment</li> <li>• Gradient pressure aid</li> <li>• Light therapy</li> <li>• Sphygmomanometers</li> </ul>

	<ul style="list-style-type: none"> <li>• Walkers</li> </ul> <p>Precertification is required for:</p> <ul style="list-style-type: none"> <li>• All rental DME equipment</li> <li>• Certain DME</li> </ul> <p>For code-specific requirements, visit our provider website. Request precertification with a Certificate of Medical Necessity (CMN) — available on our website — or by submitting a physician order and Amerigroup Referral and Authorization Request form.</p> <p>You must send a complete CMN with each claim for:</p> <ul style="list-style-type: none"> <li>• Hospital beds</li> <li>• Support surfaces</li> <li>• Motorized wheelchairs</li> <li>• Manual wheelchairs</li> <li>• Continuous Positive Airway Pressure (CPAP)</li> <li>• Lymphedema pumps</li> <li>• Osteogenesis stimulators</li> <li>• Transcutaneous Electrical Nerve Stimulators (TENS)</li> <li>• Seat lift mechanism</li> <li>• Power-Operated Vehicles (POV)</li> <li>• External infusion pump</li> <li>• Parenteral nutrition</li> <li>• Enteral nutrition and oxygen</li> </ul> <p>We must agree on HCPCS and/or other codes for billing, and we require you to use appropriate modifiers (NU for new equipment, RR for rental equipment).</p>
<b>Early and Periodic Screening, Diagnosis, and Treatment (EPSDT)/KAN Be Healthy Visit</b>	<ul style="list-style-type: none"> <li>• Member may self-refer.</li> <li>• Use the American Academy of Pediatrics Bright Future Periodicity Schedule and uniform set of recommendations for health care professionals including preventive pediatric dental care and document visits.</li> <li>• Note: vaccine serum is received under the Vaccine for Children (VFC) program for KanCare members age 18 and under.</li> <li>• Precertification is not required.</li> </ul>
<b>Educational Consultation</b>	Precertification is not required.
<b>Emergency Room</b>	<p>Precertification is not required.</p> <p>We must be notified within 24 hours or the next business day if a member is admitted into the hospital through the emergency room. If the hospital fails to notify within 24 hours or the next business day, the inpatient claim may be denied.</p>
<b>ENT Services (Otolaryngology)</b>	<p>Precertification is not required for a network provider for:</p> <ul style="list-style-type: none"> <li>• E&amp;M</li> <li>• Testing</li> <li>• Certain procedures</li> </ul> <p>Precertification is required for:</p> <ul style="list-style-type: none"> <li>• Tonsillectomy and/or adenoidectomy</li> <li>• Nasal/sinus surgery</li> <li>• Cochlear implant surgery and services</li> </ul> <p>For code-specific requirements, visit our provider website.</p>
<b>Family Planning/Sexually Transmitted Infections (STI) Care</b>	<p>Members may self-refer to any in-network or out-of-network provider.</p> <p>Encourage patients to receive family planning services in network to ensure continuity of service. Precertification is not required.</p>
<b>Gastroenterology Services</b>	Precertification is not required for a network provider for:

	<ul style="list-style-type: none"> <li>• E&amp;M</li> <li>• Testing</li> <li>• Certain procedures</li> </ul> <p>Precertification is required for:</p> <ul style="list-style-type: none"> <li>• Bariatric surgery</li> <li>• Insertion, removal, and/or replacement of adjustable gastric restrictive devices and subcutaneous port components</li> <li>• Upper endoscopy</li> </ul> <p>For code-specific requirements, visit our provider website.</p>
<b>Gynecology (also see Obstetrical Care)</b>	<p>Precertification is not required for a network provider for:</p> <ul style="list-style-type: none"> <li>• E&amp;M</li> <li>• Testing</li> <li>• Certain procedures</li> </ul>
<b>Hearing Aids</b>	<p>Precertification is required for digital hearing aids.</p>
<b>Hearing Screening</b>	<p>No precertification is required for:</p> <ul style="list-style-type: none"> <li>• Diagnostic and screening tests</li> <li>• Hearing aid evaluations</li> <li>• Counseling</li> </ul>
<b>Home Health Care</b>	<p>Precertification is required. Covered services include:</p> <ul style="list-style-type: none"> <li>• Skilled nursing</li> <li>• Home health aide</li> <li>• Physical, occupational and speech therapy services</li> <li>• Physician-ordered supplies</li> </ul> <p>Drugs and DME require separate precertification.</p>
<b>Hospice Care</b>	<p>Precertification is required.</p>
<b>Hospital Admission</b>	<p>Precertification is required for:</p> <ul style="list-style-type: none"> <li>• Elective admissions</li> <li>• Some same-day/ambulatory surgeries</li> </ul> <p>We must be notified within 24 hours or the next business day if a member is admitted into the hospital through the emergency room. For hospital claims not related to deliveries, if the hospital fails to notify within 24 hours or the next business day, the inpatient claim may be denied.</p> <p>Preadmission testing must be performed by an Amerigroup preferred lab vendor or network facility outpatient department. Please see our provider directory for a complete listing.</p> <p>We do not cover:</p> <ul style="list-style-type: none"> <li>• Rest cures</li> <li>• Personal comfort and convenience items</li> <li>• Services and supplies not directly related to patient care (telephone charges, take-home supplies, etc.)</li> </ul>

<b>Laboratory Services (Outpatient)</b>	<p>Precertification is required for all laboratory services furnished by non-network providers except hospital laboratory services in the event of an emergency medical condition.</p> <p>Submit all laboratory tests to Quest Diagnostics or LabCorp, the preferred lab providers for all Amerigroup members. Contact Quest or LabCorp at the numbers below to receive a Quest or LabCorp specimen drop box.</p> <p>For more information, testing solutions and services or setting up an account, contact either:</p> <ul style="list-style-type: none"> <li>• Quest Diagnostics: 1-866-MY-QUEST (1-866-697-8378) or</li> <li>• LabCorp: 1-800-345-4363</li> </ul>
<b>Medical Supplies</b>	Precertification is not required for disposable medical supplies.
<b>Medical Injectables</b>	<p>Amerigroup covers most specialty drugs under the pharmacy benefit.</p> <p>Some medical injectables require prior authorization when covered under the medical benefit and administered in the physician's office.</p>
<b>Neurology</b>	<p>Precertification is not required for a network provider for:</p> <ul style="list-style-type: none"> <li>• E&amp;M</li> <li>• Testing</li> <li>• Certain other procedures</li> </ul> <p>Precertification is required for:</p> <ul style="list-style-type: none"> <li>• Neurosurgery</li> <li>• Spinal fusion</li> <li>• Artificial intervertebral disc surgery</li> </ul> <p>For code-specific requirements, visit our provider website.</p>
<b>Observation</b>	Precertification is not required for in-network observation. If your observation results in an admission, you must notify us within 24 hours or on the next business day. If the hospital fails to notify within 24 hours or the next business day, the inpatient claim may be denied.
<b>Obstetric Care</b>	<p>We only require notification for obstetric care. Precertification is not required for:</p> <ul style="list-style-type: none"> <li>• Obstetric services and diagnostic testing</li> <li>• Obstetric visits</li> <li>• Certain diagnostic tests and lab services by a participating provider</li> <li>• Prenatal ultrasounds</li> <li>• Labor and delivery</li> </ul> <p>You must notify:</p> <ul style="list-style-type: none"> <li>• Amerigroup at the first prenatal visit</li> <li>• Amerigroup within 24 hours of delivery with newborn information (please include baby's mode of delivery, gender, weight in grams, gestational age in weeks and disposition at birth)</li> <li>• Amerigroup of the mother's pediatrician selection for continuity of care</li> <li>• Kansas Department of Health and Environment (KDHE) regarding birth within 24 hours to generate a request for a state-issued Medicaid ID number</li> </ul> <p>Obstetric case management programs are available.</p> <p><b>In network:</b> We will not deny claims payment based solely on lack of notification for obstetric care (at first visit) and obstetric admissions not exceeding 48 hours after vaginal delivery and 96 hours after Cesarean section.</p> <p><b>Out-of-network:</b> If Amerigroup is not notified, our claims system will deny these claims.</p>
<b>Ophthalmology</b>	<ul style="list-style-type: none"> <li>• Precertification is not required for E&amp;M, testing and certain procedures.</li> </ul>



	<ul style="list-style-type: none"> <li>• Precertification is required for repair of eyelid defects.</li> <li>• For code-specific requirements, visit our provider website.</li> <li>• We do not cover services that are considered to be cosmetic.</li> <li>• For Ophthalmology services, call Ocular Benefits at 1-855-812-9214.</li> </ul>
<b>Oral Maxillofacial</b>	See Plastic/Cosmetic/Reconstructive Surgery.
<b>Out-of-Area/Out-of-Network Care</b>	Precertification is required, except for emergency care, EPSDT screening, family planning and OB care.
<b>Outpatient/Ambulatory Surgery</b>	Precertification requirement is based on procedure performed. For code-specific requirements, visit our provider website.
<b>Pain Management/Physiatry/Physical Medicine and Rehabilitation</b>	<p>Precertification is required for non-E&amp;M-level testing and procedures.</p> <p>For code-specific requirements, visit our provider website.</p>
<b>Plastic/Cosmetic/Reconstructive Surgery (including Oral Maxillofacial Services)</b>	<p>Precertification is not required for:</p> <ul style="list-style-type: none"> <li>• E&amp;M services</li> <li>• Oral maxillofacial</li> </ul> <p>Precertification is required for:</p> <ul style="list-style-type: none"> <li>• All other services</li> <li>• Trauma to the teeth</li> <li>• Oral maxillofacial medical and surgical conditions</li> <li>• TMJ</li> </ul> <p>We do not cover:</p> <ul style="list-style-type: none"> <li>• Services considered cosmetic in nature</li> <li>• Services related to previous cosmetic procedures</li> </ul> <p>Reduction mammoplasty requires our medical director's review. For code-specific requirements, visit our provider website.</p>
<b>Radiology</b>	See Diagnostic Testing.
<b>Rehabilitation Therapy (Short Term): OT, PT, and ST</b>	<p>Precertification is not required for:</p> <ul style="list-style-type: none"> <li>• Evaluation</li> </ul> <p>Precertification is required for:</p> <ul style="list-style-type: none"> <li>• Treatments</li> <li>• Inpatient rehabilitation</li> </ul> <p>Therapy to improve a child's ability to learn and participate in school should be evaluated for school-based therapy. Therapies for rehabilitative care are evaluated for medical necessity.</p>
<b>Sleep Studies</b>	Precertification is required.
<b>Sterilization</b>	<p>Precertification is not required for:</p> <ul style="list-style-type: none"> <li>• Sterilization</li> <li>• Tubal ligation</li> <li>• Vasectomy</li> </ul> <p>We require a sterilization consent form for claims submissions. We do not cover reversal of sterilization.</p>
<b>Urgent Care Center</b>	Precertification is not required for a participating facility.
<b>Waiver Services</b>	Precertification is required for all waiver-related services.
<b>Well-woman Exam</b>	<p>Precertification is not required. We cover one well-woman exam per year when performed by her PCP or an in-network GYN. It includes:</p> <ul style="list-style-type: none"> <li>• Examination</li> <li>• Routine lab work</li> </ul>

	<ul style="list-style-type: none"> <li>• STI screening</li> <li>• Mammogram screening for women age 40 and older; precertification is required for women age 39 and younger</li> <li>• Pap smears</li> </ul> <p>Members can receive family planning services without precertification at any qualified provider. Encourage patients to receive family planning services in-network to ensure continuity of service.</p>
<b>Revenue (RV) Codes</b>	<p>Precertification is required for services billed by facilities with RV codes for:</p> <ul style="list-style-type: none"> <li>• Inpatient, including psychiatric admissions, community medical detox and PRTFs</li> <li>• OB</li> <li>• Home health care</li> <li>• Hospice</li> <li>• CT and nuclear cardiology</li> <li>• Chemotherapeutic agents</li> <li>• Pain management</li> <li>• Rehabilitation (physical/occupational/respiratory therapy)</li> <li>• Rehabilitation, short term (speech therapy)</li> <li>• Specialty agents <ul style="list-style-type: none"> <li>– Refer to the Quick Tools on our website for code-specific precertification requirement status</li> </ul> </li> </ul> <p>For a complete list of specific RV codes, visit <a href="http://providers.amerigroup.com/KS">providers.amerigroup.com/KS</a>.</p>

We have clinical staff available 24 hours a day, 7 days a week to accept precertification requests. When a medical request is received, we:

- Verify our member's eligibility and benefits
- Determine the appropriateness of the request
- Issue you a reference number

For urgent requests, we give you a decision within one business day. If documentation is not complete, we will ask for additional necessary documentation.

If your request is denied by our medical director, you will have the opportunity to discuss your case with him or her before the final determination. We will mail a denial letter to the hospital; the member's PCP and the member and include the member's appeal and fair hearing rights and process.

For services that do require prior approval, Amerigroup will approve or deny the request within 14 calendar days for standard requests and three business days for expedited requests.

Amerigroup may extend these time frames by up to 14 calendar days if you or the member requests an extension, or if Amerigroup justifies a need for additional information and how the extension is in the member's best interest. If we extend the time frame, we will send a written notice to the member of the reason and inform the member of the ability to file a grievance if he or she disagrees with that decision. Amerigroup will issue and carry out our determination as expeditiously as the member's health condition requires and no later than the date the extension requires. For authorization decisions not reached within the federal regulatory time frames, Amerigroup will send a notice of action on the date that the time frame expires.

### 5.3 Discharge Planning

Our UM clinician coordinates our members' discharge planning needs with the hospital utilizations review/case management staff and the attending physician. The attending physician coordinates follow-up care with the member's PCP, and the PCP contacts the member to schedule it.

For ongoing care, we work with the provider to plan discharge to an appropriate setting such as:

- Hospice facility
- Home health care program (e.g., home I.V. antibiotics)
- Long-term services and supports
- Nursing facilities
- Therapies in outpatient settings
- Waiver programs

#### **5.4 Emergent Admissions**

We request network hospitals to notify us within one business day of emergent admission. Network hospitals can call our Provider Services team 24 hours a day, 7 days a week at 1-800-454-3730 or send a fax to 1-800-964-3627 (this includes holidays).

Our medical management staff will verify eligibility and determine coverage. A concurrent review nurse will review and authorize the coverage of emergent admissions.

Documentation must be complete. We will notify the hospital to submit whatever additional documentation is necessary.

If our medical director denies coverage, the attending provider will have an opportunity to discuss the case with him or her. The attending emergency room physician or provider actually treating the member is responsible until, and to determine when, the member is stabilized. We will mail a denial letter to the hospital; the member's PCP and the member and include the member's appeal and fair hearing rights and process.

#### **5.5 Emergency Services**

Emergency services require no precertification. We do not deny access to or discourage our members from using 911 or accessing emergency services when warranted. As a matter of course, we grant authorizations for these services immediately.

When a member seeks emergency services at a hospital, he or she is examined by a licensed physician to determine if a need exists for such services. The physician will note the results of the emergency medical screening examination on the member's chart.

If there is a concern about transferring the member, we defer to the judgment of the attending physician. If the emergency department cannot stabilize and release our member, we will help coordinate the inpatient admission.

Any transfer from a non-network hospital to a network hospital can only take place after the member is medically stable.

#### **Emergency Room Prudent Layperson Review**

Emergency Room (ER) claims review compares the admission and discharge diagnosis codes on each claim against a KDHE approved list for outpatient hospital claims. If the admission or discharge (principal) diagnosis codes match a diagnosis code on the list, the claim will process for reimbursement per the hospital's contract. If the admission or discharge diagnosis codes do not match a diagnosis code on the list, the claim will process for reimbursement at the current outpatient rate. An Explanation of Payment (EOP) will indicate the rate, including an explanation code with the option to dispute within 90 calendar days by completing a Provider Payment

Dispute and Correspondence Submission form and submit the medical records. Medical records should not be submitted with the initial claim.

All hospital claims disputes of outpatient-level reimbursements must be submitted in writing and filed within 90 calendar days of the date on the EOPs in order to be considered. Each claims dispute should include the Amerigroup Provider Payment Dispute and Correspondence Submission form as the cover page with ER Hospital Claim Dispute written or typed clearly.

All written correspondence must clearly indicate you are requesting a claims dispute of an ER outpatient payment. The ER medical records and written rationale supporting the claims dispute should be mailed to us.

## **5.6 Inpatient Admissions**

Notification is required within 24 hours or by the next business day for any inpatient admission, including behavioral health admissions, whether emergent or previously authorized. The referring physician identifies the need to schedule a hospital admission. To send notification you can:

- Submit through [providers.amerigroup.com/KS](https://providers.amerigroup.com/KS)
- Fax the request to 1-800-964-3627
- Call Provider Services

We also require precertification of all inpatient admissions. The referring PCP or specialist is responsible for precertification for a planned inpatient admission. Submit requests for precertification with all supporting documentation immediately upon identifying the inpatient request or at least 72 hours prior to the scheduled or rescheduled admission. This will allow us to verify benefits and process the precertification request. For services that require precertification, we make case-by-case determinations that consider the individual's health care needs and medical history in conjunction with nationally recognized standards of care. The hospital can confirm that a precertification is on file by:

- Visiting our provider website
- Calling our Provider Services team

For planned inpatient admissions, if coverage has not been approved, the facility should call our Provider Services team. We will contact the referring physician directly to resolve the issue.

We are available 24 hours a day, 7 days a week to accept precertification requests. When a request is received from the physician online, via telephone or fax for medical services, a care specialist will verify eligibility and benefits. This information will be forwarded to the precertification clinician.

Our precertification clinician will review the coverage request and supporting medical documentation to determine the medical appropriateness of all procedures. When appropriate, our medical director will assist the physician to identify alternatives for health care delivery.

When the clinical information received is in accordance with the definition of medical necessity and in conjunction with nationally recognized standards of care, we will issue an Amerigroup reference number to the referring physician. All utilization guidelines must be supported by an individualized determination of medical necessity based on the member's needs and medical history.

If medical necessity criteria for the admission are not met on the initial review, the requesting provider will be able to discuss the case with the Amerigroup medical director or a psychiatrist in the case of behavioral health admission requests prior to the determination.

If the precertification documentation is incomplete or inadequate, the precertification clinician will not approve coverage of the request but will notify the referring provider to submit the additional necessary documentation.

If the medical director or psychiatrist if the request is for a behavioral health admission denies coverage of the request, the appropriate denial letter (including the member's and fair hearing appeal rights) will be mailed to the requesting provider, member's PCP and member.

### **5.7 Inpatient Reviews**

We must be notified within 24 hours or by the next business day when a member is admitted directly to the hospital through the emergency room.

#### **Inpatient Admission Review**

We review all inpatient hospital admissions and urgent and emergent admissions within one business day of notification. We determine the member's medical status through:

- Onsite review
- Communication with the hospital's Utilization Review department

We then document the appropriateness of stay and refer specific diagnoses to our case management staff for care coordination or case management.

#### **Inpatient Concurrent Review**

To determine the authorization of coverage, we conduct a concurrent review of the hospital medical record:

- At the hospital
- By telephone or fax

We conduct continued stay reviews and review discharge plans. Our Utilization Management (UM) clinician will also try and meet with the member and family to:

- Discuss any discharge planning needs
- Verify they know the member's PCP's name, address and telephone number

We authorize the covered length of stay one day at a time. Our medical director can make exceptions for severe illness and course of treatment or when it is predetermined by state law. Examples include ICU, CCU and Cesarean section or vaginal deliveries.

We will communicate approved days and bed-level coverage to the hospital for any continued stay.

### **5.8 Nonemergent Outpatient and Ancillary Services**

We require precertification for coverage of certain nonemergent outpatient and ancillary services (see previous chart). To ensure timeliness, you must include:

- Member name and ID
- Name, telephone number and fax number of the physician providing the service
- Name of the facility and telephone number where the service will be performed
- Name of servicing provider and telephone number
- Date of service
- Diagnosis with ICD code
- Name of elective procedure with CPT-4 or HCPCS codes
- Medical information to support the request
  - Signs and symptoms
  - Past and current treatment plans, along with the provider who provided the surgery

- Response to treatment plans
- Medications, along with frequency and dosage

For the most up-to-date precertification/notification requirements, visit [providers.amerigroup.com/KS](http://providers.amerigroup.com/KS) and click on Precertification Lookup.

### **Place of Service Billing Guidelines**

The following place of service (POS) codes should be used in outpatient settings:

- POS 19 (Off-Campus Outpatient Hospital) – A portion of an off-campus hospital provider based department which provides diagnostic, therapeutic (both surgical and nonsurgical), and rehabilitation services to sick or injured persons who do not require hospitalization or institutionalization. Place of service 19 will not be used for Outpatient Observations (procedure codes 99217 – 99226 and 99234 – 99236) or Emergency Room Visits (procedure codes 999281 – 99285).
- POS 22 (On Campus Outpatient Hospital) – A portion of a hospital's main campus which provides diagnostic, therapeutic (both surgical and nonsurgical), and rehabilitation services to sick or injured persons who do not require hospitalization or institutionalization.

Physicians/practitioners who perform services in a hospital campus outpatient department will use place of service (POS) code 22 (On campus outpatient hospital). POS 22 will be used unless the physician maintains separate office space in the hospital or on the hospital campus and that physician office space is not considered a provider-based department of the hospital as defined in 42. C.F.R. 413.65.

Physicians/practitioners who perform services in an off campus hospital outpatient department will use place of service (POS) 19 (Off campus-outpatient hospital). POS 19 will be used unless the physician maintains separate office space in an off-campus hospital and that physician office space is not considered a provider based department of the hospital as defined in 42.C.F.R 413.65.

Physicians will use POS code 11 (office) when services are performed in a separately maintained physician office space in the hospital, on hospital campus or off campus and that physician office space is not considered a provider-based department of the hospital as defined in 42.C.F.R. 413.65.

### **5.9 Urgent Care/After-hours Care**

We require our members to contact their PCPs if they need urgent care. If you are unable to see the member, you can refer him or her to one of our participating urgent care centers or another provider who offers after-hour care. Precertification is not required.

If you refer a member to an out-of-network provider, notification to Amerigroup is required.

We strongly encourage PCPs to provide evening and Saturday appointment access. To learn more about participating in the after-hour care program, please call your local Provider Relations representative.

## 6. PROVIDER TYPES, ACCESS AND AVAILABILITY

### 6.1 Primary Care Provider Responsibilities

You are responsible for the complete care of your patient, including:

- Providing primary care
- Provide the level of care and range of services necessary to meet the medical needs of members, including those with special needs and chronic conditions
- Coordinating and monitoring referrals to specialist care
- Coordinating and monitoring referrals to specialized behavioral health in accordance with state requirements
- Referring patients to subspecialists and subspecialty groups and hospitals for consultation and diagnostics according to evidence-based criteria for such referrals as it is available
- Authorizing hospital services
- Maintaining continuity of care
- Assuring all medically necessary services are made available in a timely manner
- Providing services ethically and legally and in a culturally competent manner
- Monitoring and following up on care provided by other medical service providers for diagnosis and treatment
- Maintaining a medical record of all services rendered by you and other referral providers
- Communicating with members about treatment options available to them, including medication treatment options, regardless of benefit coverage limitations
- Providing a minimum of 32 office hours per week of appointment availability as a Primary Care Provider (PCP)
- Providing hours of operation for members that are no less than the hours of operation offered to any other patient
- Arranging for coverage of services to assigned members 24 hours a day, 7 days a week in person or by an on-call physician
- Offering evening and Saturday appointments for members (strongly encouraged for all PCPs)
- Continuing care in progress during and after termination of your contract for up to 60 days until a continuity of care plan is in place to transition the member to another provider or through postpartum care for pregnant members in accordance with applicable state laws and regulations
- Coordination of care for members with substance use disorder services programs in support of member recovery

You also have the responsibility to:

- **Communicate with Members**
  - Make provisions to communicate in the language or fashion primarily used by the member; contact our customer care center for help with oral translation services if needed
  - Freely communicate with members about their treatment, regardless of benefit coverage limitations
  - Provide complete information concerning their diagnoses, evaluations, treatments and prognoses and give members the opportunity to participate in decisions involving their health care
  - Advise members about their health status, medical care and treatment options, regardless of whether benefits for such care are provided under the program
  - Advise members on treatments that may be self-administered
  - Contact members as quickly as possible for follow-up regarding significant problems and/or abnormal laboratory or radiological findings
- **Maintain Medical Records**
  - Treat all members with respect and dignity

- Provide members with appropriate privacy
  - Treat members' disclosures and records confidentially, giving members the opportunity to approve or refuse their release
  - Maintain the confidentiality of family planning information and records for each individual member, including those of minor patients
  - Comply with all applicable federal and state laws regarding the confidentiality of patient records
  - Agree that any notation in a patient's clinical record indicating diagnostic or therapeutic intervention as part of the clinical research shall be clearly contrasted with entries regarding the provision of nonresearch-related care
  - Share records subject to applicable confidentiality and HIPAA requirements
  - Obtain/store medical records from any specialty referrals in members' medical records
  - Manage the medical and health care needs of members to assure all medically necessary services are made available in a timely manner
- **Cooperate and Communicate With Amerigroup**
    - Participate in:
      - Internal and external quality assurance
      - Utilization review
      - Continuing education
      - Other similar programs
      - Complaint and grievance procedures when notified of a member grievance
    - Inform Amerigroup if a member objects to provision of any counseling, treatments or referral services for religious reasons
    - Identify members with special health care needs during the course of any contact or member-initiated health care visit and report these members to us so we can help them with additional services
    - Identify members who would benefit from our case management/disease management programs
    - Comply with our Quality Improvement program initiatives and any related policies and procedures to provide quality care in a cost-effective and reasonable manner
- **Cooperate and Communicate With Other Providers**
    - Monitor and follow up on care provided by other medical service providers for diagnosis and treatment, including services available under Medicaid fee-for-service
    - Provide the coordination necessary for the referral of patients to specialists and for the referral of patients to services that may be available through Medicaid
    - Provide case management services to include but not be limited to screening and assessing, developing a plan of care to address risks, medical/behavioral health needs and other responsibilities as defined in the state's program
    - Coordinate the services Amerigroup furnishes to the member with the services the member receives from any other Managed Care Organization (MCO) network program during member transition
    - Share with other health care providers serving the member the results of your identification and assessment of any member with special health care needs (as defined by the state) so those activities are not duplicated
- **Cooperate and Communicate With Other Agencies**
    - Maintain communication with the appropriate agencies such as:
      - Local police
      - Social services agencies
      - Poison control centers
      - Women, Infants and Children (WIC) program
    - Develop and maintain an exposure control plan in compliance with Occupational Safety and Health Administration (OSHA) standards regarding blood-borne pathogens



- Establish an appropriate mechanism to fulfill obligations under the Americans with Disabilities Act
- Coordinate the services Amerigroup furnishes to the member with the services the member receives from any other MCO during ongoing care and transitions of care

## 6.2 Who Can Be a Primary Care Provider?

Physicians with the following specialties can apply for enrollment with Amerigroup as a PCP in the KanCare program:

- Advanced registered nurse practitioner under the supervision of a physician
- Family practitioner
- General practitioner
- Geriatrician
- Indian health service/Tribal 638 providers
- Internist
- OB-GYNs or midwives, only when selected by women when they are pregnant
- Pediatrician
- Physician's assistant under the supervision of a physician
- Specialist (as determined by health risk appraisal and an Amerigroup network provider)
- FQHC and RHC providers

As a PCP, you may practice in a:

- Solo or group setting
- Clinic (e.g., an FQHC or RHC)
- Outpatient clinic
- Nursing facility
- Indian health/Tribal 638 facility

## 6.3 Primary Care Provider Onsite Availability

You are required to abide by the following standards to ensure access to care for our members:

- Offer 24-hour-a-day, 7-day-a-week telephone access for members. A 24-hour telephone service may be used. The service may be answered by a designee such as an:
  - On-call physician
  - Nurse practitioner with physician backup
- Be available to provide medically necessary services. You or another physician must offer this service.
- Follow our referral/precertification guidelines. This is a requirement for covering physicians.

**We encourage you to offer after-hours office care in the evenings and on Saturdays. It is not acceptable to automatically direct the member to the emergency room when the PCP is not available.**

## 6.4 Primary Care Provider Access and Availability

The ability for Amerigroup to provide quality access to care depends upon your accessibility.\* You are required to adhere to the following access standards:

Type of Care	Standard
Emergency	Immediately
Urgent care	Within 48 hours
Routine or preventive care	Within three weeks

\*In-office wait time for scheduled appointments should not routinely exceed 45 minutes, including time in the waiting room and examining room.

Walk-in patients with nonurgent needs should be seen if possible or scheduled for an appointment consistent with written scheduling procedures. Each patient should be notified immediately if the provider is delayed for any period of time. If the appointment wait-time is anticipated to be more than 45 minutes, the patient should be offered a new appointment.

As part of our commitment to providing the best quality provider networks for our members, we conduct annual telephonic surveys to verify provider appointment availability and after-hours access. Providers will be asked to participate in this survey each year.

Providers may not use discriminatory practices such as:

- Showing preference to other insured or private-pay patients
- Maintaining separate waiting rooms
- Maintaining appointment days
- Denying or not providing to a member any covered service or availability of a facility
- Condition the provision of care or otherwise discriminate against our members based on whether the members have executed advance directives
- Providing to a member any covered service that is different or is provided in a different manner or at a different time from that provided to other members, other public or private patients or the public at large

We will routinely monitor providers' adherence to access-to-care standards and appointment wait times. You are expected to meet federal and state accessibility standards and those standards defined in the Americans with Disabilities Act of 1990. Health care services provided through Amerigroup must be accessible to all members.

For urgent care and additional after-hours care information, see the Urgent Care/After-hours Care section of this manual.

### **6.5 Specialty Care Providers**

A specialty care provider is a network physician responsible for providing specialized care for members, usually upon appropriate referral from members' PCPs.

To assist PCPs in meeting the needs of children with mental health diagnosis, Amerigroup provides access to consultations with child psychiatrists and other qualified behavioral health professionals. For more information on how to arrange for these consultations, call our Provider Services team.

### **Access to Women's Health Specialists**

Female members may directly access women's health specialists within our network for covered routine and preventive health care services, including maternity care, reproductive health services, gynecological care, and general examination, preventive care as medically appropriate and medically appropriate follow-up visits for these services.

Newly diagnosed pregnant women must be seen within their first trimesters or within 10 calendar days from notification. Postpartum exams should be given between 21 and 56 days after deliveries, regardless of the needs for Caesarean section postoperative visits.

### **6.6 Role and Responsibilities of Specialty Care Providers**

As a specialist, you will treat members who are:

- Referred by network PCPs
- Self-referred

You are responsible for:

- Complying with all applicable statutory and regulatory requirements of the Medicaid program
- Accepting all members referred to you
- Rendering covered services only to the extent and duration indicated on the referral
- Submitting required claims information, including source of referral and referral number
- Arranging for coverage with network providers while off duty or on vacation
- Verifying member eligibility and precertification of services at each visit
- Providing consultation summaries or appropriate periodic progress notes to the member's PCP on a timely basis
- Notifying the member's PCP when scheduling a hospital admission or scheduling any procedure requiring the PCP's approval
- Coordinating care with other providers for:
  - Physical and behavioral health comorbidities
  - Co-occurring behavioral health disorders
- Adhering to the same responsibilities as the PCP

### 6.7 Specialty Care Providers' Access and Availability

The ability for Amerigroup to provide quality access to care depends upon your accessibility.\* You are required to adhere to the following access standards:

Type of Care	Standard
Emergency	Immediately
Urgent care	Within 48 hours of referral
Nonurgent sick care	Within 10 calendar days
Routine lab, X-ray (Radiology) and optometry	Within three weeks
Mental health	<ol style="list-style-type: none"> <li>1. Poststabilization: Within one hour from referral for poststabilization services (both inpatient and outpatient) in an emergency room.</li> <li>2. Emergent: Within three hours for an outpatient MH services; within one hour from referral for an emergent concurrent utilization review screen</li> <li>3. Urgent: 48 hours from referral for outpatient MH services; within 24 hours from referral for an urgent concurrent utilization review screen.</li> <li>4. Planned Inpatient Psychiatric: Referral within 48 hours; assessment and/or treatment within five working days from referral.</li> <li>5. Routine Outpatient: Referral within five days; assessment and/or treatment within nine working days from referral and/or 10 working days from previous treatment.</li> </ol>
Substance Use Disorder (SUD) services	<p><b><i>Emergent:</i></b> Treatment is considered an on demand service and does not require precertification. Members are asked to go directly to an emergency room for services if individual is either unsafe or their condition is deteriorating.</p> <p><b><i>Urgent:</i></b> Means a service need that is not emergent and can be met by providing an assessment within 24 hours of the initial contact, and services delivered within 48 hours from initial contact without resultant deterioration in the individual's functioning or worsening of his or her condition. If the Member is pregnant they are to be placed in the urgent category.</p> <p><b><i>Routine:</i></b> Means a service need that is not urgent and can be met by a receiving an assessment within 14 calendar days of the initial contact, and treatment within 14 calendar days of the assessment, without resultant</p>

	<p>deterioration in the individual's functioning or worsening of his or her condition.</p> <p><b>IV Drug Users:</b> If a Member has used IV drugs within the last six months, and they do not fall into the Emergent or Urgent categories because of clinical need, they will need to be placed in this category. Members who have utilized IV drugs within the last six months need to be seen for treatment within 14 calendar days of initial contact. There is not a time standard requirement for the assessment, nor is there an IV Drug User category in the KCPC.</p> <p>These members are categorized as routine but are to receive treatment within 14 days of their initial contact, not within 14 days of their assessment.</p>
All other specialty care	Within 30 calendar days

\*In-office wait time for scheduled appointments should not routinely exceed 45 minutes, including time in the waiting room and examining room.

Each patient should be notified immediately if the provider is delayed for any period of time. If the appointment wait time is anticipated to be more than 45 minutes, the patient should be offered a new appointment. Walk-in patients with nonurgent needs should be seen if possible or scheduled for an appointment consistent with written scheduling procedures.

As part of our commitment to providing the best quality provider networks for our members, we conduct annual telephonic surveys to verify provider appointment availability and after-hours access. Providers will be asked to participate in this survey each year.

Providers may not use discriminatory practices such as:

- Showing preference to other insured or private-pay patients
- Maintaining separate waiting rooms
- Maintaining appointment days
- Denying or not providing to a member any covered service or availability of a facility (except in cases where Indian health service/Tribal 638 providers are prohibited from providing certain services due to cultural beliefs)
- Condition the provision of care or otherwise discriminate against our members based on whether the members have executed advance directives
- Providing a member with any covered service that is different from, administered in a different manner than or at a different time than that given to other members, other public or private patients, or the public at large

We will routinely monitor providers' adherence to access-to-care standards and appointment wait times. You are expected to meet federal and state accessibility standards and those standards defined in the Americans with Disabilities Act of 1990. Health care services provided through Amerigroup must be accessible to all members.

For urgent care and additional after-hours care information, see the Urgent Care/After-hours Care section of this manual.

## 6.8 Indian Health Services, Urban Indian Health Clinics Tribal Health Centers

To promote culturally sensitive and convenient health care, our members are permitted to seek care from any Indian Health Services (IHS) or Tribal care provider defined in the Indian Health Care Improvement Act, 25 U.S.C. §§1601, et seq., regardless of whether the provider participates in the Amerigroup provider network.

Individuals enrolled in a federally recognized Indian Nation may access IHS, Urban Indian Health Clinics Tribal 638 and may see providers at will and without referral. We do not prevent members who are IHS beneficiaries from seeking care from IHS and Tribal Providers or from network providers due to their status as Native Americans.

***Precertification is not required for services provided within the IHS, Urban Indian Health Clinics and Tribal 638 network.***

We accept a current license to practice in the United States or its territories from any individual provider employed by the IHS, Urban Indian Health Clinic or Tribal 638 facility and consider receipt of this license to meet licensure requirements for our network participation. Also, any provider of SUD treatment services in a facility setting must be licensed by the state to provide SUD treatment services.

#### **6.9 Out-of-Network Providers**

Out-of-network providers must coordinate with Amerigroup with respect to payments and ensure any cost to members is no greater than it would be if services were furnished within the network.

## **7. PROVIDER PROCEDURES, TOOLS AND SUPPORT**

### **7.1 Behavioral Health Consultations**

Amerigroup will provide all Kansas contracted Primary Care Providers (PCPs) with opportunities to consult with Behavioral Health specialists through a secure portal available through our provider self-service site — [providers.amerigroup.com/KS](https://providers.amerigroup.com/KS). For more information about this and other Behavioral Health consultation resources please visit our site or call our Provider Services team at 1-800-454-3730.

Pregnant woman with behavioral health conditions often present with multiple, complex issues that could require specialist referrals and/or coordination of care. For assistance obtaining consultations from or referrals to behavioral health specialists to assist care management for these members or to make referrals for care coordination services, call our Provider Services team.

### **7.2 Behavioral Health Screening Tools**

We also provide screening tools on our provider self-service site for common behavioral health disorders like depression, Alzheimer's Disease/dementia and substance use. If you have any questions about use of these tools, call our Provider Services team.

### **7.3 Changes in Address and/or Practice Status**

To maintain the quality of our provider data and assure timely notices and payment, please submit changes to your practice contact information, payment address or the information of participating providers within your practice as soon as you are aware of the change.

Report status or address changes by visiting [providers.amerigroup.com/KS](https://providers.amerigroup.com/KS), calling our Provider Services team, or writing to:

Provider Relations Department  
Amerigroup Kansas, Inc.  
9225 Indian Creek Parkway, Building 32  
Overland Park, KS 66210  
Phone: 913-749-5955  
Fax: 1-866-494-5632

### **7.4 Clinical Practice Guidelines**

We work with you and providers in our community to develop clinical policies and guidelines. Each year, we select at least four evidence-based clinical practice guidelines that are relevant to our members and measure at least two important aspects of each of those four guidelines. We also review and revise these guidelines at least every two years. You can find these Clinical Practice Guidelines on our website.

### **7.5 Covering Physicians**

During your absence or periods of unavailability, you must arrange for coverage for our members assigned to your panel. You will be responsible for making arrangements with:

- One or more network providers to get care for our members
- Other similarly licensed and qualified participating providers who have appropriate medical staff privileges at the same network hospitals or medical groups to get care for our members

The covering providers must agree to the terms and conditions of our network provider agreement, including applicable limitations on compensation, billing and participation.

You are solely responsible for:

- A non-network provider's adherence to our network provider agreement
- Any fees or monies due and owed to any non-network provider who offers substitute coverage to our members on the provider's behalf

## **7.6 Cultural Competency**

With the increasing diversity of the populations enrolled in Medicaid managed care, and particularly in the KanCare program, it is important to work effectively in cross-cultural situations. Your ability to relate with your patients has a profound impact on the effectiveness of the health care you provide. Your patients must be able to communicate symptoms clearly and understand your recommended treatments.

Our cultural competency training program at [providers.amerigroup.com/KS](http://providers.amerigroup.com/KS) helps you:

- Acknowledge the importance of culture and language
- Embrace cultural strengths with people and communities
- Assess cross-cultural relations
- Understand cultural and linguistic differences
- Strive to expand your cultural knowledge

Remember:

- The perception of illnesses, diseases and their causes varies by culture
- Belief systems on health, healing and wellness are very diverse
- Culture influences help-seeking behaviors and attitudes toward health care and service providers
- Individual preferences affect traditional and nontraditional approaches to health care
- Patients must overcome their personal biases toward health care systems
- Providers from culturally and linguistically diverse groups are currently and generally under-represented in the broader health care system

Cultural barriers can affect your relationship with your patients, including:

- Our member's comfort level and his or her fear of what you might find in an examination
- Different levels of understanding among diverse consumers
- A fear of rejection of personal health beliefs
- A member's expectation of what you do and how you treat him or her

To help overcome these barriers, you need the following cultural awareness, knowledge and skills.

### **Cultural Awareness**

- Recognize the cultural factors that shape personal and professional behavior, including:
  - Norms
  - Values
  - Communication patterns
  - World views
- Modify your own behavioral style to respond to others' needs while maintaining your objectivity and identity

### **Knowledge**

- Culture plays a crucial role in the formation of health and illness beliefs
- Culture is generally behind a person's acceptance or rejection of medical advice
- Different cultures have different attitudes about seeking help
- Feelings about disclosure are culturally unique

- The acceptability and effectiveness of treatment modalities are different in various cultural and ethnic groups
- Verbal and nonverbal language, speech patterns, and communication styles vary by culture and ethnic groups
- Resources like formally trained interpreters should be offered to and used by members with various cultural and ethnic differences

### **Skills**

- Understand the basic similarities and differences between and among the cultures of the people we serve
- Recognize the values and strengths of different cultures
- Interpret diverse cultural and nonverbal behavior
- Develop perceptions and understanding of others' needs, values and preferred ways of having those needs met
- Identify and integrate the critical cultural elements to make culturally consistent inferences and demonstrate that consistency in actions
- Recognize the importance of time and the use of group process to develop and enhance cross-cultural knowledge and understanding
- Withhold judgment, action or speech in the absence of information about a person's culture
- Listen with respect
- Formulate culturally competent treatment plans
- Use culturally appropriate community resources
- Know when and how to use interpreters and understand the limitations of using interpreters
- Treat each person uniquely
- Recognize racial and ethnic differences and know when to respond to culturally based cues
- Seek out information
- Use agency resources
- Respond flexibly to a range of possible solutions
- Accept ethnic differences among people and understand how these differences affect treatments
- Work willingly with clients of various ethnic minority groups

### **7.7 Fraud, Waste and Abuse**

As the recipient of funds from federal and state-sponsored health care programs, we have a duty to help prevent, detect and deter fraud, waste and abuse. Our corporate compliance program, Code of Business Conduct and Ethics, and fraud, waste and abuse policies are available for review on our provider website.

As part of the requirements of the Federal Deficit Reduction Act, you are required to adopt our policies on fraud, waste and abuse.

Methods to report fraud, waste and abuse:

- Make anonymous reports to [www.amerigroup.silentwhistle.com](http://www.amerigroup.silentwhistle.com)
- Make anonymous reports by leaving a message at 757-518-3633
- Send an email to [corpinvest@amerigroup.com](mailto:corpinvest@amerigroup.com)
- Call our Provider Services team
- Reach out directly to our Chief Compliance Officer at 757-473-2711 or send an email to [ethics@amerigroup.com](mailto:ethics@amerigroup.com)

**You are the first line of defense against fraud, waste and abuse.** Examples include:



**Provider Fraud, Waste and Abuse**

- Billing for services not rendered
- Billing for services that were not medically necessary
- Double billing
- Unbundling
- Upcoding

To help prevent fraud, waste and abuse, make sure your services are:

- Medically necessary
- Documented accurately
- Billed according to guidelines

**Member Fraud, Waste and Abuse**

- Benefit sharing
- Collusion
- Drug trafficking
- Forgery
- Illicit drug seeking
- Impersonation fraud
- Misinformation/misrepresentation
- Subrogation/third-party liability fraud
- Transportation fraud

To help prevent member fraud, waste and abuse:

- Educate members
- Be observant
- Spend time with members and review their prescription record
- Review their Amerigroup member ID card
- Make sure the cardholder is the person named on the card
- Encourage members to protect their ID cards like they would credit cards or cash
- Encourage them to report any lost or stolen card to us immediately

We also encourage our members to report any suspected fraud, waste and abuse by:

- Calling our Member Services team at 1-800-600-4441
- Emailing [corpinvest@amerigroup.com](mailto:corpinvest@amerigroup.com)
- Contacting our Chief Compliance Officer at 757-473-2711
- Sending an anonymous report to [www.amerigroup.silentwhistle.com](http://www.amerigroup.silentwhistle.com)

We will not retaliate against any individual who reports violations or suspected fraud, waste and abuse; we will make every effort to maintain anonymity and confidentiality.

In the event that Amerigroup identifies and validates an incident of fraud, waste or abuse, we disclose that information to Kansas Department of Health and Environment (KDHE), apply a statistical sample and extrapolation method to estimate overpayments and pursue recoveries consistent with commonly accepted practices. Providers are required to repay all identified overpayments – this is addressed within The Patient Protection and Affordable Care Act (PPACA).

**7.8 Health Insurance Portability and Accountability Act**

The Health Insurance Portability and Accountability Act (HIPAA):

- Improves the portability and continuity of health benefits

- Provides greater patient rights to access and privacy
- Ensures greater accountability in health care fraud
- Simplifies the administration of health insurance

We are committed to safeguarding patient/member information. As a contracted provider, you must have procedures in place to demonstrate compliance with HIPAA privacy and security regulations. You must also have safeguards in place to protect patient/member information such as locked cabinets clearly marked and containing only protected health information, unique employee passwords for accessing computers and active screen savers.

Member individual privacy rights include the right to:

- Receive a copy of our notice of privacy practices
- Request and receive a copy of his or her medical records and request those records be amended or corrected
- Get an accounting of certain disclosures of his or her Protected Health Information (PHI)
- Ask that his or her PHI not be used or shared
- Ask each provider to communicate with him or her about PHI in a certain way or location
- File a complaint with his or her provider or the Secretary of Health and Human Services if privacy rights are suspected to be violated
- Designate a personal representative to act on his or her behalf
- Authorize disclosure of PHI outside of treatment, payment or health care operations and cancel such authorizations

We only request the minimum member information necessary to accomplish our purpose. Likewise, you should only request the minimum member information necessary for your purpose. However, regulations do allow the transfer or sharing of member information between Amerigroup and a provider to:

- Conduct business and make decisions about care
- Make an authorization determination
- Resolve a payment appeal

Requests for such information fit the HIPAA definition of treatment, payment or health care operations.

You should maintain fax machines used for transmitting and receiving medically sensitive information in a restricted area. When faxing information to us, please:

- Verify the receiving fax number
- Notify us you are faxing information
- Verify that we received your fax

Do not use internet email (unless encrypted) to transfer files containing member information to us. You should mail or fax this information. Mail medical records in a sealed envelope marked **confidential** and addressed to a specific individual or department in our company.

Our voice mail system is secure and password-protected. You should only leave messages with the minimum amount of member information necessary.

When contacting us, please be prepared to verify your:

- Name
- Address
- NPI number

- TIN
- Amerigroup provider number

### **7.9 Lab Requirements — Clinical Laboratory Improvement Amendments**

Amerigroup is bound by the Clinical Laboratory Improvement Amendments (CLIA) of 1988. The purpose of the CLIA program is to ensure laboratories that test specimens in interstate commerce consistently provide accurate procedures and services.

As a result of CLIA, any laboratory that solicits or accepts specimens in interstate commerce for laboratory testing is required to hold a valid license or letter of exemption from licensure issued by the Secretary of the Department of Health and Human Services. Since 1992, carriers have been instructed to deny clinical laboratory services billed by independent laboratories that do not meet the CLIA requirements.

You must provide Amerigroup with a copy of your CLIA certificate and notify us if your CLIA status changes. Finally, the CLIA number must be included on each CMS-1500 claim form for laboratory services by any laboratory performing tests covered by CLIA.

### **7.10 Marketing — Prohibited Provider Activities**

The state of Kansas is responsible for all marketing during the enrollment process.

Amerigroup does not influence enrollment in our plan by offering any compensation, reward, or benefit to potential members except for additional health-related services or informational or educational services that have been approved by the state.

Amerigroup and its subcontractors, including health care providers, will not directly solicit potential members and will fully comply with the following marketing restrictions:

- Will not, directly or indirectly, conduct door-to-door, telephonic or other forms of “cold-call” marketing
- Will not communicate to a person who is not enrolled in our plan in any way that can be reasonably interpreted as intending to influence the person to enroll in our plan or to influence any enrollment or disenrollment decisions the person might make
- Will ensure marketing materials do not contain any assertion or statement (whether written or oral) that:
  - The recipient must enroll in Amerigroup in order to obtain benefits or in order not to lose benefits
  - We are endorsed by CMS, the federal or state government or similar entity
- Will not distribute any marketing materials without first obtaining the state’s approval
- Will not distribute marketing materials to our membership, unless otherwise approved by the state
- Will not offer the sale of any other type of insurance product as an enticement to enrollment
- Will ensure our marketing materials are accurate, do not contain false or misleading information, and do not mislead, confuse or defraud the recipients or the state
- Will not discriminate against individuals eligible to be covered on the basis of health status or need of health services and will accept individuals in the order in which they apply without restriction, (unless authorized by the Regional Administrator), up to the limits set under the contract
- Will not seek to influence enrollment in conjunction with the sale or offering of any private insurance

Amerigroup has stringent review processes in place that ensure that all of our materials meet state requirements.

Providers are permitted to tell members the names of the KanCare MCOs with which they participate; however, providers cannot direct or encourage members to choose a specific MCO.

### 7.11 Health Assessment

We are offering all members the opportunity to complete a Health Risk Assessment (HRA) following enrollment so we can better identify member needs and refer members to appropriate programs and services. As part of the HRA process, we are making member responses available for providers to review via the Amerigroup provider website. After successfully logging into the provider website, select **Patient & Support**, then **Member Health Assessment**. Follow the instructions as indicated on the website to review the status and results of your member's health assessment. We encourage providers to utilize this information as you assess the needs of your patients.

### 7.12 Permitted Sanctions

In the event a provider fails to meet any performance standard or other requirement or rule of any agency, or any standard or rule existing under applicable law pertaining to the services provided hereunder, we may assess liquidated damages, sanctions or reductions in payment in an amount equal to any penalty actually assessed by the agency, or under applicable law, against Amerigroup, due to such performance standard not having been met or due to the breach of such requirement, role or obligation under your provider agreement. Liquidated damages, sanctions or payment reductions for selected failures of performance will be specifically set forth in future versions of this provider manual once the state of Kansas issues directives regarding the scope and type of sanctions permitted.

Rest assured, Amerigroup will work diligently with our network providers to negotiate mutually agreeable corrective action plans and time periods to address any performance issues or failure to meet standards well before any damages or sanctions are put forth.

### 7.13 Records Standards — Member Medical Records

We require medical records to be current, detailed and organized for effective, confidential patient care review. Your medical records must conform to good professional medical practice and must be permanently maintained at the primary care site.

Members are entitled to one copy of their medical record each year, and the copy is provided at no cost to the member. Members or their representatives should have access to these records.

Our medical records standards include:

1. Patient identification information — patient name or ID number must be shown on each page or electronic file
2. Personal/biographical data — age, gender, address, employer, home and work telephone numbers, and marital status
3. Date and corroboration — dated and identified by the author
4. Legibility — if someone other than the author judges it illegible, a second reviewer must evaluate it
5. Allergies — must note prominently:
  - Medication allergies
  - Adverse reactions
  - No Known Allergies (NKA)
6. Past medical history — for patients seen three or more times. Include serious accidents, operations, illnesses and prenatal care of mother and birth for children
7. Immunizations — a complete immunization record for pediatric members age 20 and younger with vaccines and dates of administration
8. Diagnostic information
9. Medical information — including medication and instruction to patient
10. Identification of current problems
  - Serious illnesses

- Medical and behavioral conditions
  - Health maintenance concerns
11. Instructions — including evidence the patient was provided basic teaching and instruction for physical or behavioral health condition
  12. Smoking/alcohol/substance use — notation required for patients age 12 and older and seen three or more times
  13. Consultations, referrals and specialist reports — consultation, lab and X-ray reports must have the ordering physician's initials or other documentation signifying review; any consultation or abnormal lab and imaging study results must have an explicit notation
  14. Emergencies — all emergency care and hospital discharge summaries for all admissions must be noted
  15. Hospital discharge summaries — must be included for all admissions while enrolled and prior admissions when appropriate
  16. Advance directive — must document whether the patient has executed an advance directive such as a living will or durable power of attorney

### **Documentation Standards for an Episode of Care**

When we request clinical documentation from you to support claims payments for services, you must ensure the information provided to us:

- Identifies the member
- Is legible
- Reflects all aspects of care

To be considered complete, documentation for episodes of care will include, at a minimum, the following elements:

- Patient identifying information
- Consent forms
- Health history, including applicable drug allergies
- Types and dates of physical examinations
- Diagnoses and treatment plans for individual episodes of care
- Physician orders
- Face-to-face evaluations
- Progress notes
- Referrals
- Consultation reports
- Laboratory reports
- Imaging reports (including X-ray)
- Surgical reports
- Admission and discharge dates and instructions
- Preventive services provided or offered appropriate to the member's age and health status
- Evidence of coordination of care between primary and specialty physicians

Refer to the standard data elements to be included for specific episodes of care as established by The Joint Commission (TJC), formerly the Joint Commission on Accreditation of Healthcare Organizations (JCAHO). A single episode of care refers to continuous care or a series of intervals of brief separations from care to a member by a provider or facility for the same specific medical problem or condition.

Documentation for all episodes of care must meet the following criteria:

- Be legible to someone other than the writer
- Contain information that identifies the member on each page in the medical record

- Contain entries in the medical record that are dated and include author identification (e.g., handwritten signatures, unique electronic identifiers or initials)

#### **Other documentation not directly related to the member**

Other documentation not directly related to the member but relevant to support clinical practice may be used to support documentation regarding episodes of care, including:

- Policies, procedures and protocols
- Critical incident/occupational health and safety reports
- Statistical and research data
- Clinical assessments
- Published reports/data

We may request that you submit additional documentation, including medical records or other documentation not directly related to the member, to support claims you submit. If documentation is not provided following the request or notification or if documentation does not support the services billed for the episode of care, we may:

- Deny the claim
- Recover and/or recoup monies previously paid on the claim

Amerigroup is not liable for interest or penalties when payment is denied or recouped because the provider fails to submit required or requested documentation.

#### **7.14 Records Standards — Patient Visit Data**

You must provide:

1. A history and physical exam with both subjective and objective data for presenting complaints
2. Behavioral health treatment, including at-risk factors:
  - Danger to self/others
  - Ability to care for self
  - Affect
  - Perpetual disorders
  - Cognitive functioning
  - Significant social health
3. Admission or initial assessment must include:
  - Current support systems
  - Lack of support systems
4. Behavioral health treatment — documented assessment at each visit for client status and symptoms, indicating:
  - Decreased
  - Increased
  - Unchanged
5. A plan of treatment, including:
  - Activities
  - Therapies
  - Goals to be carried out
6. Diagnostic tests
7. Behavioral health treatment — evidence of family involvement in therapy sessions and/or treatment
8. Follow-up care encounter forms or notes indicating follow-up care, call or visit in weeks, months or PRN
9. Referrals and results of all other aspects of patient care and ancillary services

We systematically review medical records to ensure compliance, and we institute actions for improvement when our standards are not met.

We maintain a professional recordkeeping system for services to our members. We make all medical management information available to health professionals and state agencies and retain these records for seven years from the date of service.

### 7.15 Referrals

Members can access the following services ***without referrals or precertification***:

- Preventive and routine services
- KAN Be Healthy (EPSDT) services
- Routine shots
- Screening or testing for sexually transmitted diseases (including HIV)
- Services from IHS or Tribal care providers defined in the Indian Health Care Improvement Act, 25 U.S.C. §§1601, et seq., regardless of whether the provider participates in the Amerigroup provider network
- Assessment for Outpatient Substance Use Disorder services
- Emergency care
- Well-woman services

Your office staff and our members can find PCPs and specialty care providers nearby through our searchable online directory. Upon completion of credentialing and contracting with us, you will receive your user ID and password for our provider website. Nonparticipating providers have the ability to create a user id and log in to our provider self-service site once one claim has been submitted to Amerigroup and is processed.

View the online directory by:

- Logging in to our provider website
- Selecting Referral Info from the Tools menu
- Selecting either Searchable Directory or Downloadable Directories from the Referral Info drop-down menu

When considering recommendation of Substance Use Disorder (SUD) treatments and services to our members, use of Kansas Client Placement Criteria (KCPC) American Society of Addition Medicine (ASAM) criteria for determining the level of care and treatment is required.

### 7.16 Rights and Responsibilities of Our Members

Our members have rights and responsibilities. ***A full list of these rights and responsibilities is provided to each of our members within our Member Handbook.*** Outlined below are the high-level rights of our members.

#### Member Rights

##### General Member Rights

Each managed care member is guaranteed the following rights and protection:

- Dignity and privacy: the right to be treated with respect and with due consideration for his or her dignity and privacy
- Receive information on available treatment options: the right to receive information on available treatment options and alternatives, presented in a manner appropriate to his or her condition and ability to understand
- Participate in decisions: the right to participate in decisions regarding his or her health care, including the right to refuse treatment
- Remain free from restraint or seclusion: the right to be free from any form of restraint or seclusion used

as a means of coercion, discipline, convenience or retaliation

- Receive a copy of medical records: the right to request and receive a copy of his or her medical records and request that they be amended or corrected, as specified in 45 CFR 164
- Be free to exercise his or her rights and be sure the exercise of those rights does not adversely affect the way Amerigroup and its providers or the state treat him or her

#### **Informed Consent**

Members also have the right to:

- Give consent to treatment or care
- Ask providers about the side effects of care for themselves or their children
- Know about side effects of care and give consent before getting care for themselves or their children

#### **Advance Directives**

Members also have the right to use advance directives to put their health care choices into writing. They may also name someone to speak for them if that member is unable to speak.

Kansas state law has two kinds of advance directives:

- Durable power of attorney for health care — names someone to make medical decisions for the member if he or she is not able to make his or her own decisions
- Directive to physicians (living will) — tells the doctor/doctors what a member does or does not want if a terminal condition arises or if the member becomes permanently unconscious

#### **Amerigroup Information**

Members also have the right to:

- Receive the necessary information to be an Amerigroup member in a manner and format they can understand easily
- Receive a current member handbook and a provider directory
- Receive assistance from Amerigroup in understanding the requirements and benefits of the plan
- Receive notice of any significant changes in the benefit package at least 30 days before the intended effective date of the change
- Make recommendations about our rights and responsibilities policies
- Know how we pay our providers

### **7.17 Rights of Our Providers**

Each network provider who contracts with Amerigroup to furnish services to members has the right to:

- While acting within the lawful scope of practice, advise or advocate on behalf of a member who is his or her patient regarding:
  - The member's health status, medical care or treatment options, including any alternative treatment that may be self-administered
  - Any information the member needs in order to decide among all relevant treatment options
  - The risks, benefits and consequences of treatment or nontreatment
  - The member's right to participate in decisions regarding his or her health care, including the right to refuse treatment and express preferences about future treatment decisions
- Receive information on the grievance, appeal and State Fair Hearing procedures
- Have access to Amerigroup policies and procedures covering the authorization of services
- Be notified of any decision by Amerigroup to deny a service authorization request or authorize a service in an amount, duration or scope that is less than requested
- Challenge on the member's behalf, at the request of the Medicaid/CHIP member, the denial of coverage or payment for services



- Be free from discrimination where Amerigroup selection policies and procedures govern particular providers that serve high-risk populations or specialize in conditions that require costly treatment
- Be free from discrimination for the participation, reimbursement or indemnification of any provider who is acting within the scope of his or her license or certification under applicable state law, solely on the basis of that license or certification

### **7.18 Satisfaction Surveys**

We conduct annual surveys to assess your satisfaction with network participation onboarding processes, communications, education, complaints resolution, claims processing and reimbursements, and utilization management processes, including medical reviews.

We'll send you advance notice or call to let you know when and how to participate in our surveys. We want your feedback!

### **7.19 State Fair Hearing Process for Providers**

KDHE requests all providers to exhaust all levels of MCO appeals processes before seeking State Fair Hearings. Once all MCO levels of appeal are exhausted, providers have full access to the State Fair Hearing process.

Providers have the ability to file a State Fair Hearing for denials of payment for services *after the services were rendered* in cases where there is no member liability.

### **7.20 Support and Training for Providers**

#### **Support and Communication Tools**

We support you with meaningful online tools and telephone access to Provider Services at our National Contact Centers and our local Provider Relations representatives (PR reps).

- Providers Services supports your inquiries about member benefits and eligibility, and authorizations and claims issues.
- Our local PR reps are assigned to all participating providers, facilitate your orientations and education programs and may visit your office to share information on at least an annual basis.

We also communicate with you and your office staff through newsletters, alerts and updates posted to our provider website or sent via email, fax or regular mail.

#### **Training**

We conduct initial training of newly contracted providers and provider groups, in addition to ongoing training to ensure compliance with KDHE guidelines and requirements. We provide resource materials through in-person orientation sessions, mailings and on our provider website.

We will announce, in advance and via mail and/or provider website notices, the schedule of these training sessions offered to all providers and their office staff. Training is offered in large-group settings, via webinars or in person as appropriate. We maintain records of providers and staff who attend training and assess participant satisfaction with our training sessions and content as appropriate.

#### **Continuing Medical Education Credits**

You and your office staff may be able to obtain Continuing Medical Education (CME) credits by completing our cultural competency training program and other programs we plan to offer. Continue to check the Training

section of our provider website and be on the lookout for newsletter stories or announcements about additional CME-qualified courses we plan to make available in the future.

## 8. TOOLS TO HELP YOU MANAGE OUR MEMBERS

### 8.1 Eligibility (Panel) Listings

Online panel listings are updated daily to make the most current member information available for review and download. Access your panel listings online through our provider self-service site:

- 1) Go to [providers.amerigroup.com/KS](http://providers.amerigroup.com/KS) and enter your user ID and password.
- 2) Click Eligibility & Panel Listing in the orange Tools menu on the right side of the page.
- 3) Click PCP Member Listing on the list that appears.
- 4) Select TIN, Provider Name and Date Range.
- 5) Click the blue Show Listing box.
- 6) Click the blue Download button to sort and import the results to an Excel spreadsheet.

Member panel listings are mailed only upon request — call our Provider Service team or your local Provider Relations representative.

### 8.2 Identification Cards

Member identification card samples:



Mobile ID Card smartphone app – Via our new app, available for both iOS and Android users, members can download an image of their current ID cards and fax or email you a copy

### 8.3 Members With Special Needs

The term special needs is used broadly to include members with behavioral health needs or major chronic and complex conditions, as well as children and youth with special health care needs.

The term special health care needs includes any physical, developmental, mental, sensory, behavioral, cognitive or emotional impairment, or limiting condition that requires medical management, health care intervention and/or use of specialized services or programs. The condition may be developmental or acquired and may cause limitations in performing daily self-maintenance activities or substantial limitations in a major life activity.

Health care for individuals with special needs requires specialized knowledge, increased awareness and attention, adaptation, and accommodative measures beyond what are considered routine. In general, those with functional impairments resulting from chronic illness, residing in a nursing facility or intermediate care facility for people with intellectual or developmental disabilities (ICF/IDD), participating in a waiver program or at high risk for a disabling condition or adverse birth outcome will be engaged in the Amerigroup health care management process and/or service coordination.

**A nonurgent condition for an otherwise healthy member may indicate an urgent care need for a member with special needs.**

Through our intensive service coordination and care-management program, we have processes in place to assist with:

- Well-child care
- Health promotion and disease prevention
- Specialty care
- Diagnostic and intervention strategies
- Therapies
- Ongoing ancillary services
- Long-term management of ongoing medical complications
- Long-term services and supports
- Reintegrations from institutional settings to communities
- Care management systems for assuring children with serious, chronic and rare disorders receive appropriate diagnostic workups on a timely basis

**We coordinate with qualified community health homes and contract with community organizations such as substance use disorder treatment facilities and long-term care agencies to provide a full range of services for members with special needs.**

We have policies and procedures to allow for continuation of existing relationships with out-of-network providers when considered to be in the best medical interest of the member.

We, with the assistance of our network providers, will identify members who are at risk of or have special needs. The identification will include the application of screening procedures for new members. These will include a review of hospital and pharmacy utilization. We will develop care plans, as appropriate, with the member and his or her representatives that address the member's service requirements with respect to specialist physician care, durable medical equipment, home health services, transportation, etc. The care management system is designed to ensure that all required services are furnished on a timely basis and that communication occurs between network and non-network providers if applicable.

We work to ensure a new member with complex/chronic conditions receives immediate transition planning. The transition plan will include the following:

- Review of existing care plans
- Preparation of a transition plan that ensures continual care during the transfer to the plan

If a new member, upon enrollment, or a member, upon diagnosis, requires very complex, highly specialized health care services over a prolonged period of time, the member may receive care from a participating specialist or a participating specialty care center with expertise in treating the life-threatening disease or specialized condition.

Case/care managers, providers and Member Services staff are able to serve members with behavior problems associated with developmental disabilities, including the extent to which these problems affect the member's level of compliance.

Individuals with Special Health Care Needs (ISHCN) means persons who have, or are at an increased risk for a chronic physical, developmental, behavioral, neurobiological or emotional condition, or who have low to severe

functional limitation and who also require health and related services of a type or amount beyond that required by individuals generally.

Amerigroup defines all members that have met a nursing facility level of care as ISHCN (KanCare waiver, Institutional Nursing Facility and KanCare). Other members may be identified based on referrals from Amerigroup staff, family members, caretakers, providers, service coordinators, state agencies or other third parties.

ISHCN require a broad range of primary, specialized medical, behavioral health and related services. ISHCN have ongoing health conditions, high or complex service utilization, and low to severe functional limitations. The Amerigroup provider network consists of primary, specialized, medical, behavioral and social services to meet these needs.

Amerigroup will:

- Incorporate into our Member Handbook a description of network providers and programs available to ISHCN
- Identify ISHCN among our membership, using the criteria for identification and information provided by HSD/MAD
- Work with HSD/MAD to develop and implement written policies and procedures, which govern how members with multiple and complex physical health care needs shall be identified
- Target members for the purpose of applying stratification criteria to ISHCN

Amerigroup will employ reasonable effort to identify ISHCNs based at least on the following criteria:

- Individuals eligible for SSI
- Individuals enrolled in the home and community-based waiver programs such as, KanCare waiver Children receiving foster care or adoption assistance support
- Individuals identified by service utilization, clinical assessment or diagnosis
- Referral by family or a public or community program

Within 10 days of enrolling in our KanCare program, the member will receive a welcome call from Amerigroup.

Amerigroup manages the service needs of ISHCN through a Service Coordinator. The Service Coordinator will work with the member and his or her family or caregiver to:

- Assess the member's needs, including physical health, mental health, social and long term support services
- Develop an Individualized Service Plan (ISP). The ISP includes but is not limited to:
  - The member's medical history
  - A summary of the member's current medical and social needs and concerns
  - Short- and long-term care needs and goals
  - A list of required services and how often these services are needed
  - Details on who will provide these services
  - Information about KanCare and 1915(c) waiver services
  - A list of specific waiver service network providers in your area from which the member can choose
- Help arrange timely access to a wide range of providers and services related to ISHCN, including but not limited to:
  - Direct access to KanCare specialty providers as needed
  - Rehabilitation therapy services
  - Utilization management services
- Help arrange other services given outside the ISP, as needed

- Review the member's care needs and help him or her with access to care, specialty referrals, DME and PCP changes
- Contact the member based on his or her first health risk screen to find out if the member has a PCP that can best serve the member based on his or her health care needs
- Ensure a Case Manager is assigned at the time of the initial health screen, if needed
- Help set up PCP visits and referrals for ongoing case management as needed
- Teach and allow the member and his or her family or caregivers to make informed decisions based on the member's ISP or treatment plan

Amerigroup adheres to clear expectations and requirements related to ISHCNs that may include but are not limited to:

- Direct access to specialists, as needed
- Relevant KanCare specialty providers for ISHCNs
- Relevant KanCare emergency resource requirements for ISHCNs
- Relevant KanCare rehabilitation therapy services to maintain functionality for ISHCNs
- Relevant KanCare clinical practice guidelines for provision of care and services to ISHCNs
- Relevant KanCare utilization management for services to ISHCNs

#### **8.4 Member Grievances**

Our members have the right to say they are dissatisfied with Amerigroup or a provider's service and operations.

**Only a member, a member's authorized representative or a provider acting on behalf of a member with the member's written consent may file a grievance.**

A member can file a grievance orally by calling Member Services at 1-800-600-4441. He or she can also file a grievance in person or by mail. Any supporting documents must be included. Grievances in person or by mail should be directed to:

Administrative Review and Grievance Department  
Amerigroup Kansas, Inc.  
9225 Indian Creek Parkway, Building 32  
Overland Park, KS 66210

Member grievances do not involve:

- Medical management decisions
- Interpretation of medically necessary benefits
- Adverse determinations

These are called appeals and are addressed in the appeals sections of this manual.

Members must file grievances within 180 calendar days of the date they became aware of the problem. We will acknowledge receipt of each grievance, either orally or in writing, within 10 business days.

We investigate each grievance and all of its clinical aspects. Urgent or emergent grievances are resolved within 24 hours of receipt. For nonemergent grievances, we inform the member, investigate the grievance and resolve it within 30 business days from the date we received the grievance. This includes:

- For clinical issues, a written disposition of the grievance within five business days of determination
- For nonclinical issues, a written or oral disposition of the grievance within five business days of determination

Sometimes an extension may be necessary to fully resolve the member's grievance. The State must approve the extension and be informed of how the extension is in the best interest of the member. The extension must not exceed an additional 14 calendar days. The member will receive written notice of the reason for the decision to extend the time frame and how the extension is in their best interest. The member will also be informed of their right to file a grievance if they disagree with the extension. The determination will be issued and carried out as expeditiously as the member's health condition requires and no later than the date the extension expires.

Members do not have the rights to hearings in regard to the dispositions of grievances.

We will notify the member in writing of:

- The names(s), titles(s) and, in the case of a grievance with a clinical component, qualifying credentials of the person or persons completing the review of the grievance
- The disposition of the grievance
- Policies and procedures regarding the decision
- The right to further remedies allowed by the law
- How the grievance process may be continued with Kansas Department of Health and Environment (KDHE) if the member does not agree with the resolution after the member has exhausted all levels of our grievance process
- How the member may be advised or represented by a lay advocate, attorney or other representative as chosen by the member and agreed to by the representative

### 8.5 Member Appeals

A member, a member's authorized representative or a provider acting on behalf of a member with the member's written consent may file an appeal:

- For an appeal of standard service authorization decisions, a member must file an appeal, either orally or in writing, within 33 calendar days of the mailing date on the Amerigroup Notice of Action.
- For an expedited appeal when your health requires a decision about services to be made as quickly as possible, a member or member's representative can ask Amerigroup to make a decision about the expedited appeal within three working days after receiving the request. An expedited appeal may be filed in writing or by calling Amerigroup.
- For an appeal for termination, suspension or reduction of previously authorized services when the member requests continuation of such services, the member must file an appeal within 10 calendar days of the mailing date on the Amerigroup Notice of Action.
- For HCBS/LTSS members, those services will continue for 33 days from the mailing date of Amerigroup's Notice of Action to allow members time to file an appeal or ask for a State Fair Hearing.
- Oral inquiries seeking to appeal actions shall be treated as appeals and be confirmed in writing within 10 days, unless the members or providers request expedited resolutions.

We will inform the member of the limited time he or she has to present evidence and allegations of fact or law with expedited resolution. We also will ensure that no punitive action will be taken against a provider who supports an expedited appeal.

Our goal is to handle and resolve every appeal as quickly as the member's health condition requires. Our established time frames are:

- ***Standard resolution of appeal and for appeals for termination, suspension or reduction of previously authorized services:*** 30 business days from the date of receipt of the appeal. We can extend this time frame if the member requests extension or if Amerigroup shows the state that there is a need for additional information and how the delay is in the member's interest. We will notify the member by whatever means

are available (i.e., mail, telephone, or email) of the reason for the extension. The extension cannot delay the decision beyond 28 calendar days of the request of the extension.

- ***Expedited resolution of appeal, including notice to the affected parties:*** no longer than three calendar days from receipt of the appeal, except for those appeals related to an ongoing emergency or denial of continued hospitalization, which will be resolved within 1 business day of receipt of the appeal.
- ***Appeals relating to an ongoing emergency or denial of continued hospitalization:*** no longer than one business day after receiving the member's request for expedited appeal. This time frame cannot be extended.

The notice of the resolution of the appeal shall be in writing. For notice of an expedited resolution, we will also make reasonable efforts to provide oral notice. We will include the date completed and reasons for the determination in easily understood language. A written statement of the clinical rationale for the decision, including how the requesting provider or member may obtain the utilization management clinical review or decision-making criteria, will be issued.

If an appeal is not wholly resolved in favor of the member, the notice will include:

- The right for our member to request a State Fair Hearing and how to do so
- The right to receive benefits while this hearing is pending and how to request them
- Notice that the member may have to pay the cost of these benefits if the State Fair Hearing officer upholds the Amerigroup action

Members have the right to ask for a State Fair Hearing at any time, unless they want to file an expedited appeal. If they want to file an expedited appeal, members must go through the Amerigroup appeal process before asking for an expedited State Fair Hearing. In the case of a standard appeal, members must ask for a State Fair Hearing within 33 calendar days from the mailing date on the letter from Amerigroup that tells them the result of their appeal. A member, a member's representative or a provider acting on behalf of a member with the member's written consent may file a State Fair Hearing.

Effectuation of reversed appeal resolutions for services:

- 1) If the member does not receive services while the appeal is pending:
  - a) If the MCO or the SFH officer reverses the decision to deny, limit or delay services and the services were not furnished while the appeal was pending, the MCO must authorize or provide the disputed services promptly or as expeditiously as the member's health condition requires.
- 2) If the member receives services while the appeal is pending:
  - a) If the MCO or the SFH officer reverses the decision to deny authorization of services and the member has received the services being disputed during the appeal process, the MCO or the State must pay for those services in accordance with State policy and regulations.

### **Expedited Appeals**

Our expedited appeal process is available upon the member's request or when a provider indicates a standard resolution could seriously jeopardize the member's life, health or ability to attain, maintain or regain maximum function. The member or provider may file an expedited appeal either orally or in writing. No additional written follow-up on the part of the member or the provider is required for an oral request for an expedited appeal.

No punitive actions are taken against providers who request expedited resolutions or support members' appeals.

Amerigroup will resolve each expedited appeal and provide notice to the member as quickly as the member's health condition requires and within three calendar days after receipt of the expedited appeal request.



If your request is deemed to be a nonexpedited issue, our standard timeline for appeals will apply and the member will receive notification that the appeal is being transferred to the standard appeal process.

Members have rights to file grievances regarding our denial of requests for expedited resolutions. We will inform members of their right to file grievances in the notices of denial.

### **Continuation of Benefits**

We are required to continue a member's benefits while the appeals process or the State Fair Hearing is pending if all of the following are true:

- The appeal is submitted to us on or before the latter of the two: within 10 calendar days of our mailing the notice of action or the intended effective date of our proposed action.
- The appeal involves the termination, suspension or reduction of a previously authorized course of treatment.
- Services were ordered by an authorized provider, as applicable.
- The original period covered by the original authorization has not expired.
- The member continues to be enrolled to a category of eligibility for which the service is a benefit.
- The member requests an extension of benefits.
- For HCBS/LTSS members, benefits will automatically continue for 33 days from the mailing date of the Notice of Action to allow time to file an appeal with Amerigroup or ask for a State Fair Hearing. If a member asks for an Amerigroup appeal or State Fair Hearing and has requested benefits to continue, the benefits will continue until one of the following occurs:
  - Member withdraws the appeal.
  - Ten days pass after the notice providing resolution of the appeal is mailed and the resolution is against the member. However, if the member requests a State Fair Hearing within the 10-day time frame, the benefits will continue until a State Fair Hearing decision has been reached.
  - A State Fair Hearing office issues a hearing decision adverse to the member.
  - The time period or service limits of a previously authorized service has been met.

If the decision is against the member, we may recover the cost of the services the member received while the appeal was pending. For HCBS/LTSS members, if the Amerigroup appeal is denied or the action taken by Amerigroup is approved by the Office of Administrative Hearings, members will not have to repay Amerigroup for services provided during the appeal or State Fair Hearing unless fraud has occurred.

### **8.6 Member Missed Appointments**

At times, members may cancel or not attend necessary appointments and fail to reschedule, which can be detrimental to their health. You should attempt to contact any member who has not kept or canceled an appointment without rescheduling. Contact the member by telephone to:

- Educate him or her about the importance of keeping appointments
- Encourage him or her to reschedule the appointment

For members who frequently cancel or fail to keep appointments, please call our Provider Services team to address the situation. Our goal is for members to recognize the importance of maintaining preventive health visits and to adhere to a plan of care recommended by their PCPs.

### **8.7 Member Noncompliance**

Contact our Provider Services team if you have an issue with a member regarding:

- Behavior
- Treatment cooperation
- Completion of treatment

- Continuously missed or rescheduled appointments

We will contact the member to provide the education and counseling to address the situation and will report to you the outcome of any counseling efforts.

### **8.8 Second Opinions**

A member, parent and/or legally appointed representative or the member's PCP may request a second opinion in any situation where there is a question concerning a diagnosis or the options for surgery or other treatment of a health condition. The second opinion shall be provided at no cost to the member.

The second opinion must be obtained from a network provider or a non-network provider if there is not a network provider with the expertise required for the condition. Authorization is required for a second opinion if the provider is not a network provider. Once approved, you will notify the member of the date and time of the appointment and forward copies of all relevant records to the consulting provider. You will notify the member of the outcome of the second opinion.

We may also request a second opinion at our own discretion. This may occur under the following circumstances:

- Whenever there is a concern about care expressed by the member or the provider
- Whenever potential risks or outcomes of recommended or requested care are discovered by the plan during our regular course of business
- Before initiating a denial of coverage of service
- When denied coverage is appealed
- When an experimental or investigational service is requested

A second opinion from an expert in child psychiatry is required in order to obtain authorization to prescribe a psychotropic medication for a child under 5 years of age.

When we request a second opinion, we will make the necessary arrangements for the appointment, payment and reporting. We will inform you and the member of the results of the second opinion and the consulting provider's conclusion and recommendation(s) regarding further action.

### **8.9 Administrative Lock-In Program**

Members determined to be abusing medical coverage may be restricted to one primary care physician (PCP), one pharmacy, and one hospital (for nonemergency services). The initial Lock-In period for all newly identified members is 24 months. A member who has completed the initial 24-month period and who is subsequently found to have misused benefits for a second time will be placed in extended Lock-In with no termination date. Immediate placement in the Lock-In Program can be initiated if a member is convicted of fraud or abuse. Members placed into the Lock-In Program will receive a certified Initial Placement Letter that includes:

- The reasons the member was found to have misused medical or pharmacy benefits.
- Names and locations of assigned providers (PCP, pharmacy and hospital).
- Notification of the opportunity to change the providers within 10 days after receipt of the letter.
- The member will be held liable for medical bills incurred if the member accesses nonemergent services from a non-Lock-In provider.
- The assigned PCP must provide a referral for specialty services prior to the service being rendered.
- Notification of appeal and fair hearing rights.

In the assignment of providers, Amerigroup will consider geographic location and reasonable travel time, claims evidence that the member has an established provider(s), and any Lock-Out restrictions.

If the member accesses nonemergent services from an unassigned Lock-In provider, the member will be held responsible for those medical bills. The member must always coordinate services through the assigned providers.

Members who were placed in Lock-In by the Kansas Department of Health and Environment and for whom Amerigroup is honoring the Lock-In status, an extension of the appeal rights for placement into Lock-In will not be extended.

### **Assignment of a Member in the Lock-In Program**

Lock-In providers will be notified via written communication of those members who have been assigned to them.

The assigned or selected PCP will be notified in writing of the member's placement into the Lock-In program. The notification will include:

- A list of the member's assigned providers
- General information regarding the Lock-In process and program
- A questionnaire to be completed by the PCP designed to collect information supporting the reason for Lock-In
- A Lock-In Referral Form

Lock-in providers are never required to provide services or medications not supported by medical necessity. The member is expected to actively share in the Lock-In responsibility by only receiving health care, prescription medications and hospital outpatient services from the assigned Lock-In providers. If the Lock-In member fails to follow medical advice, the Lock-In providers are not required to provide requested referrals or treatment.

**The Lock-In physician is the primary prescribing physician.** Narcotics and controlled substances should only be prescribed by the Lock-In physician or approved by his or her specific referral .

If the assigned provider is dissatisfied with the member assignment and would like to be removed, then the provider, pharmacy or hospital for nonemergent services may contact the Lock-In Coordinator through Provider Services at 1-800-454-3730, ext. 35736.

**The assigned Lock-In pharmacy will be the only pharmacy authorized to fill prescriptions for the member.** The pharmacy should assist in the member's care by reviewing the prescription history and contacting the prescriber when necessary to ensure coordinated care.

### **Lock-In Override Exceptions**

#### **Pharmacy Issue – Medication Out of Stock**

When the assigned Lock-In pharmacy does not have medication to fill a prescription, the member will be allowed to have the prescription filled at a pharmacy that has the medication in stock. The assigned Lock-In pharmacy or the member may contact the Lock-In Coordinator to advise Amerigroup that the member is unable to fill the prescription. The Lock-In Coordinator will then locate a pharmacy that has the medication in stock and provide override.

#### **Provider Issue – Prescription Written by Non-Approved Prescriber**

When the member attempts to fill a controlled substance prescription from a non-approved provider at the assigned Lock-In Pharmacy, the claim will deny. The assigned Lock-In pharmacy or the member may contact the Lock-In Coordinator to advise Amerigroup that the member is unable to fill the prescription. The Lock-In

Coordinator will contact the assigned Lock-In PCP or consult with an Amerigroup Medical Director to determine if an override is appropriate. Approved overrides will be completed by the Lock-In Coordinator.

**The member will be restricted to the use of one hospital for nonemergency services.** When a Lock-In member uses the emergency room and triage reveals the symptoms are nonemergent, the Lock-In hospital can decide whether to treat or refer the member to the Lock-In physician. It is recommended that the Lock-In physician instruct the emergency room staff regarding how to handle nonemergent situations for the member.

#### **Referral Requirements**

The assigned PCP must provide a referral for specialty services prior to the service being rendered. Providers may obtain the KS Lock-In Provider Referral form from the Lock-In Coordinator through Provider Services at 1-800-454-3730, ext. 35736. This form must be completed by the assigned Lock-In PCP and sent via fax or email to the Lock-In Coordinator as specified on the form.

#### **Suspected Fraud or Abuse**

Call the Provider Services Unit at 1-800-454-3730 or provide written notification should you suspect any incidents of fraud or abuse. Send written documentation to:

Amerigroup Kansas, Inc.  
9225 Indian Creek Parkway, Building 32  
Overland Park, KS 66210  
Attn: Lock-In Program

## 9. HOW WE SUPPORT OUR MEMBERS

### 9.1 Amerigroup as the Member Health Home

KDHE recently announced their decision to discontinue the Health Homes program as a service covered by Kansas Medicaid effective on July 1, 2016.

Effective with dates of service on and after July 1, 2016, the Health Homes program will be discontinued as a service covered by Kansas Medicaid. Effective March 1, 2016, no new members will be assigned to the Health Homes program. Health Home members already assigned through the end of the program will transition to other supports in their community.

The following Health Homes description of benefits outline the program as of the decision was made to discontinue it. Updates will be made as they become available.

Please call Provider Services at 1-800-454-3730 Monday through Friday from 8 a.m. to 5 p.m. Central time if you have any questions.

We offer a Health Home program to support our members and their health by coordinating the care and services they receive. Their health home will oversee all their health care needs and make sure they get the best care available to them.

Members are eligible for health home services if they are a person with serious mental illness (SMI). The SMI population includes anyone with a primary diagnosis of one or more of the following conditions:

- Schizophrenia
- Bipolar and major depression
- Delusional disorders
- Personality disorders
- Psychosis not otherwise specified
- Obsessive-compulsive disorder
- Post-traumatic stress disorder

The following members are excluded from health homes:

- Members in a population code consistent with NF, MH NF, ICF/IDD
- Members 65 or older with a dementia diagnosis or related disorder and psychosis and/or other psychiatric conditions
- Members with ESRD undergoing dialysis
- Members who have a catastrophic illness/event requiring aggressive treatment/care and cannot reasonably be available to the health home program
- Members who have SMI diagnosis only from emergency room visit and review suggests psychiatric presentation may have been physically mediated (e.g. drug induced, etc.)
- Members in the Lock-In program
- Members in institutional settings

#### **What is a health home?**

A health home is not a place. It is a way to help make sure members can be as healthy as possible by giving them some special services. These services include:

- A care coordinator who will work with them to develop a health action plan
- A care coordinator to help them get the right services at the right time

- Help with learning about their medicines and conditions and how they can help themselves be healthier
- Help members when coming out of the hospital to make sure they can get important follow-up visits to doctors and other providers
- Help members with understanding how their family or other helpers support them in reaching their health goals
- Help members getting other services and support they need to stay in their home
- Help members with questions they may have about their health

Being in a health home allows all those who provide care to work together to give members quality health care.

Joining the Health Home program is the member's choice. If they are eligible, they will receive a welcome letter assigning them to a health home. If they choose to be in the Health Home program and have spenddown, they must meet their spenddown before they are eligible to receive health home services. They can choose to be in a Health Home program or leave the program at any time. Health Home program services are extra support to help them meet your health goals.

## **9.2 Amerigroup On Call**

Amerigroup On Call is a telephonic, 24-hour triage service your Amerigroup patients can call to speak with a registered nurse who can help them:

- Find doctors when your office is closed, whether after-hours or weekends
- Schedule appointments with you or other network doctors
- Get to urgent care centers or walk-in clinics
- Speak directly with a doctor or a member of the doctor's staff to talk about their health care needs

We encourage you to tell your Amerigroup patients about this service and share with them the advantages of avoiding the emergency room when a trip there isn't necessary or the best alternative.

Members can reach Amerigroup On Call at 1-866-864-2544 (Spanish 1-866-864-2545). TTY services are available for members who are deaf or hard of hearing, and language translation services are also available.

## **9.3 Automatic Assignment of Primary Care Providers**

When a member is enrolled with Amerigroup, we automatically assign him or her to a PCP. Amerigroup assigns a PCP to members that have KanCare as their primary coverage, as well as those with third-party or commercial insurance. Members that are dually eligible for Medicare and Medicaid are not assigned a PCP.

PCP auto-assignments are based on proximity to members' home addresses, as well as ages, genders and primary-spoken languages. If a member loses coverage for a period of time and is reinstated with Amerigroup, he or she will be assigned to the most recent provider that was previously assigned to him or her.

Members receive an Amerigroup-issued identification card that displays the PCP name and phone number, in addition to other important plan contact information.

Members may elect to change their PCPs at any time. After the member calls Amerigroup Member Services, the requested changes will become effective no later than the following day and a new ID card will be issued.

## **9.4 Advance Directives**

We adhere to the Patient Self-determination Act and recognize and support the following advance directives:

- Durable power of attorney: lets a member name a patient advocate to act on his or her behalf
- Living will: lets a member state his or her wishes on medical treatment in writing

We encourage members age 18 and older to ask you for an Advance Directive form and education at their first appointment. Please use the state of Kansas-approved Advance Directive form available at [http://www.kdads.ks.gov/SeniorServices/FAQ/faq\\_advance\\_direct.htm/public/forms.asp](http://www.kdads.ks.gov/SeniorServices/FAQ/faq_advance_direct.htm/public/forms.asp) and document receipt of their forms in your medical records.

We understand a facility or physician may conscientiously object to an advance directive. However, we also recognize the member's right to determine his or her own care.

An Amerigroup associate cannot act as a witness to an advance directive nor serve as a member's advocate or representative.

### **9.5 Case Management Services**

**Case management services are different from care coordination services.** For more detailed information about the difference between case management and care coordination, see the following sections of this manual:

- Covered Benefits through Amerigroup — care coordination description
- Members with Special Needs
- Appendix C – Procedures for skilled nursing facilities/nursing homes
- Appendix D – Procedures for providers of waiver services and other long-term services and supports

We offer case management services to meet our members' needs when they are pregnant or have conditions or diagnoses that require ongoing care and treatment, including care management for our members who require long-term services and support. Once we have identified a member's need, our nurse case managers (CMs) work with that member and the member's PCP to identify:

- The level of case or care management needed
- Appropriate alternate settings to deliver care
- Health care services
- Equipment and/or supplies
- Community-based services
- The best way to foster communication between the member and his or her PCP

For members who are hospitalized, our nurse CMs also work with our member, utilization review team, and PCP or hospital to develop a discharge plan of care and link our member to:

- Community resources
- Our outpatient programs
- Our Disease Management Centralized Case Unit (DMCCU)

### **Member Assessment**

Our nurse CMs conduct comprehensive assessments to evaluate each person's:

- Medical condition
- Previous pregnancy history
- Current pregnancy status
- Functional status
- Goals
- Life environment
- Support systems
- Behavioral health status
- Ability for self-care
- Current treatment plan

Once we communicate with members or members' representatives and get information from PCPs and specialists, we coordinate our members' current medical and nonmedical needs.

### **Plan of Care**

After the assessment, we:

- Determine the level of case or care management services
- Guide, develop and implement an individualized plan of care
- Work with the member, the member's representative and his or her family and provider

Research has shown us our members comply with their treatment plans more when they can make their own health care decisions.

We coordinate all cases of Sexually Transmitted Diseases (STDs) and tuberculosis with local health departments to ensure prevention and limit the spread of disease. We will cooperate with the treatment plan developed by the local health department for these cases.

In addition, we consider our members' needs for:

- Social services
- Educational services
- Therapeutic services
- Other nonmedical support services (Personal Care Services, WIC, transportation)

We also consider the strengths and needs of our members' family.

We collaborate with social workers and coordinate with member advocates or outreach associates to define the best ways to coordinate our members' physical, behavioral health, pregnancy and social services. We then make sure we forward all written care plans to you by fax or mail.

We welcome your referrals of patients who can benefit from our case or care management support. Please call the Amerigroup Provider Services team or visit our provider self-service site for more information.

### **9.6 Disease Management Centralized Care Unit**

Our Disease Management Centralized Care Unit (DMCCU) is based on a system of coordinated care management interventions and communications designed to help physicians and other health care professionals manage members with chronic conditions. DMCCU services include a holistic, member-centric care management approach that allows care managers to focus on multiple needs of members. Our disease management programs include:

- |  |                             |
|--|-----------------------------|
| • Asthma                                       | • HIV/AIDS                  |
| • Bipolar disorder                             | • Hypertension              |
| • Chronic Obstructive Pulmonary Disease (COPD) | • Major Depressive Disorder |
| • Congestive Heart Failure (CHF)               | • Obesity                   |
| • Coronary Artery Disease (CAD)                | • Schizophrenia             |
| • Diabetes                                     | • Substance Use Disorder    |

In addition to our 12 condition-specific disease management programs, our member-centric, holistic approach also allows us to manage members with multiple conditions like cerebrovascular disease, fibromyalgia and musculoskeletal complications.



## Program Features

- Proactive identification process
- Evidence-based clinical practice guidelines from recognized sources
- Collaborative practice models that include the physician and support providers in treatment planning
- Continuous self-management education, including:
  - Primary prevention
  - Behavior modification
  - Compliance and surveillance
  - Home visits
  - Case management for high-risk members
- Ongoing process and outcomes measurement, evaluation and management
- Ongoing communication with providers regarding patient status

Disease management clinical practice guidelines are located at [providers.amerigroup.com/KS](http://providers.amerigroup.com/KS). Simply access the Kansas state page and log into the secure site by entering your *User Name* and *Password*. Please select the **Clinical Policy & Guidelines** link on the top navigation menu. A copy of the guidelines can be printed from the website, or you can call Provider Services at 1-800-454-3730 to receive a copy.

## Who Is Eligible?

All members with the listed conditions are eligible. We identify them through:

- Continuous case finding welcome calls
- Claims mining
- Missed care opportunities
- Referrals

As a valued provider, we welcome your referrals of patients who can benefit from additional education and care management support. Our care managers will work collaboratively with you to obtain your input in the development of care plans. Members identified for participation in any of the programs are assessed and risk stratified based on the severity of their disease. They are provided with continuous education on self-management concepts, which include primary prevention, behavior modification and compliance/surveillance, as well as case/care management for high-risk members. Program evaluation, outcome measurement and process improvement are built into all the programs. Providers are given telephonic and/or written updates regarding patient status and progress.

## Disease Management Centralized Care Unit Provider Rights and Responsibilities

You have the right to:

- Have information about Amerigroup, including:
  - Provided programs and services
  - Our staff
  - Our staff's qualifications
  - Any contractual relationships
- Decline to participate in or work with any of our programs and services for your patients
- Be informed of how we coordinate our interventions with your patients' treatment plans
- Know how to contact the person who manages and communicates with your patients
- Be supported by our organization when interacting with patients to make decisions about their health care
- Receive courteous and respectful treatment from our staff
- Communicate complaints about DMCCU (see our Provider Complaint and Grievance Procedure)

## Hours of Operation

Our DMCCU case managers are licensed nurses and social workers. They are available:

- 8:30 a.m. to 5:30 p.m. local time
- Monday through Friday

Confidential voice mail is available 24 hours a day.

## Contact

You can call a DMCCU team member at 1-888-830-4300. DMCCU program content is located at [providers.amerigroup.com/KS](https://providers.amerigroup.com/KS) under the Patient & Medical Support link on the top menu. Printed copies are available upon request. Members can find out more by visiting [www.myamerigroup.com/KS](https://www.myamerigroup.com/KS).

### 9.7 Enrollment

Medicaid, CHIP and waiver population benefits recipients who meet the state's eligibility requirements for participation in managed care:

- Are automatically assigned to an MCO
- Can change MCOs during a choice period of 90 days after the initial assignments or during the annual open enrollment period
- Are automatically assigned to PCPs upon auto-assignment to MCOs but may change PCPs thereafter as frequently as desired
- Are encouraged to make appointments with their PCPs within 90 calendar days of their effective dates of enrollment

Eligible newborns born to members are automatically enrolled with Amerigroup on the date of birth in most cases. **Dual eligibles are not assigned to PCPs.**

### 9.8 Interpreter Services

No-cost interpreter services are available to members when calling our Member Services team with questions about our programs, when calling Amerigroup On Call, during appointments with health care providers and during grievance or appeals processes.

For interpretation services during scheduled appointments, call our Member Services team at 1-800-600-4441 and be ready to provide the following information:

- Appointment Type, e.g. PCP, Specialist, Behavioral Health, etc.
- Appointment date/time
- Member name
- Member number
- Provider name
- Provider address

The information will be forwarded to our in-house interpreter manager who will determine the best medium of service needed, either phone or onsite. The manager will coordinate with the member and provider to ensure access to service is available at the time of the appointment. Requests by phone should be accommodated the same day, while on-site interpretation requires five days advanced notice.

### 9.9 Provider Directories

We offer provider directories for members and referral directories for our network providers in online searchable and hard-copy formats. Since use of these directories is how members identify health care providers nearby, it is important that your practice address, doctors' names and contact information are promptly updated when changes occur. You can update your practice information by:

- Visiting [providers.amerigroup.com/KS](https://providers.amerigroup.com/KS) and logging into your secure account
- Calling Provider Services
- Calling or emailing your local Provider Relations representative

#### **9.10 Welcome Call**

In addition to mailing welcome packets that include PCP selection instructions, handbooks with benefits coverage information and provider directories, we also give new members a welcome call, within 10 days of enrollment, to:

- Educate them about our services
- Help them schedule initial checkups
- Identify any health issues (e.g., pregnancy or previously diagnosed diseases)

#### **9.11 Well-child Visits Reminder Program**

Based on our claims data, we send PCPs a list of members who have not received well-child services according to our schedule. We also mail information to these members, encouraging them to contact their PCPs to set up appointments for needed services.

Please note:

1. We list within each report the specific service each member needs.
2. You must render the services on or after the due date in accordance with the American Academy of Pediatrics Periodicity schedule for Kansas.
3. We base our list on claims data we receive before the date shown on each list. Please check to see if you have provided the services after the report run date.

## 10. QUALITY MANAGEMENT

### 10.1 Quality Management Program

We have a comprehensive Quality Management Program to monitor the demographic and epidemiological needs of the population served. You have opportunities to make recommendations for areas of improvement.

We evaluate the needs of the health plan's specific population annually, including age/gender distribution and inpatient, emergent/urgent care and office visits by type, cost and volume. In this way, we can define high-volume, high-risk and problem-prone conditions.

### 10.2 Use of Performance Data

Practitioners and providers must allow Amerigroup to use performance data in cooperation with our quality improvement program and activities.

### 10.3 Quality of Care

We evaluate all physicians, advanced registered nurse practitioners and physician assistants for compliance with:

- Medical community standards
- External regulatory and accrediting agencies requirements
- Contractual compliance

We share these reviews to enable you to increase individual and collaborative rates for members. Our quality program includes a review of quality of care issues for all care settings using:

- Member grievances
- Reported adverse events
- Other information

### Potentially Preventable Adverse Events

According to the Office of the Inspector General (OIG), preventable adverse events were generally caused by:

- Appropriate treatment provided in a substandard way (56 percent)
- Resident's progress not adequately monitored (37 percent)
- Necessary treatment not provided (25 percent)
- Inadequate resident assessment and care planning (22 percent)

### Potentially Preventable Events Related to Medication

- Change in mental status/delirium related to use of opiates and psychotropic medication
- Hypoglycemia related to use of anti-diabetic medication
- Ketoacidosis related to use of anti-diabetic medication
- Bleeding related to use of antithrombotic medication
- Thromboembolism related to use of anticoagulant medication
- Prolonged constipation/ileus/impaction related to use of opiates
- Electrolyte imbalance (including dehydration and acute kidney injury) related to the use of diuretic medication
- Drug toxicities including acetaminophen, digoxin, levothyroxine, ACE inhibitors, phenytoin, lithium, valproic acid and antibiotics
- Altered cardiac output related to use of cardiac/blood pressure medication

**Potentially Preventable Events Related to Resident Care**

- Falls, abrasions, skin tears or other trauma related to care
- Electrolyte imbalance (including dehydration and acute kidney injury/insufficiency) associated with inadequate fluid maintenance
- Thromboembolic events related to inadequate resident monitoring and provision of care
- Respiratory distress related to inadequate monitoring and provision of tracheostomy/ventilator care
- Exacerbations of preexisting conditions related to inadequate or omitted care
- Feeding tube complications (aspiration, leakage, displacement) related to inadequate monitoring and provision of care
- In-house acquired/worsened stage pressure ulcers and unstageable/suspected deep tissue injuries
- Elopement

**Potentially Preventable Events Related to Infections**

- Respiratory infections
  - Pneumonia
  - Influenza
- Skin and wound infections
  - Surgical site infections (SSIs)
  - Soft tissue and non-surgical wound infections
- Urinary tract infections (UTIs)
  - Catheter-associated UTIs
- Infectious diarrhea
  - Clostridium difficile
  - Norovirus

The results they submit to our Quality Management department are incorporated into a profile and include standards for preventive health services .

**10.4 Quality Management Committee**

The Quality Management Committee (QMC) responsibilities are to:

- Establish strategic direction and monitor and support implementation of the quality management program
- Establish processes and structure that ensure NCQA compliance
- Review planning, implementation, measurement and outcomes of clinical/service quality improvement studies
- Coordinate communication of quality management activities throughout the health plans
- Review HEDIS data and action plans for improvement
- Review and approve the annual quality management program description
- Review and approve the annual work plans for each service delivery area
- Provide oversight and review of delegated services
- Provide oversight and review of subordinate committees
- Receive and review reports of utilization review decisions and take action when appropriate
- Analyze member and provider satisfaction survey responses
- Monitor the plan's operational indicators through the plan's senior staff

### **10.5 Medical Review Criteria**

On December 24, 2012, WellPoint, Inc. (WellPoint) acquired Amerigroup and its subsidiaries. WellPoint has its own nationally recognized medical policy process for all of its subsidiary entities.

Effective May 1, 2013, Anthem medical policies, which are publicly accessible from its UniCare subsidiary website, became the primary benefit plan policies for determining whether services are considered to be a) investigational/experimental, b) medically necessary, and c) cosmetic or reconstructive for Amerigroup subsidiaries.

McKesson InterQual criteria will continue to be used when no specific UniCare medical policies exist. In the absence of licensed McKesson InterQual criteria, Amerigroup subsidiaries may use UniCare Clinical Utilization Management (UM) Guidelines. A list of the specific Unicare Clinical UM Guidelines used will be posted and maintained on the Amerigroup subsidiary websites and can be obtained in hard copy by written request. The policies described above will support precertification requirements, clinical appropriateness claims edits and retrospective review.

Federal and state law, as well as contract language, including definitions and specific contract provisions/exclusions, take precedence over medical policy and must be considered first when determining eligibility for coverage. As such, in all cases, state Medicaid contracts or Centers for Medicare and Medicaid Services (CMS) requirements will supersede both McKesson InterQual and UniCare medical policy criteria. Medical technology is constantly evolving, and we reserve the right to review and periodically update medical policy and utilization management criteria.

### **10.6 Clinical Criteria**

Amerigroup collaborates with network providers to develop clinical practice guidelines of care for our membership that are objective and based on medical evidence and nationally recognized standards of care. The Medical Advisory committee helps us formalize and monitor the clinical practice guidelines, and adopt the review criteria.

We use McKesson InterQual criterion for clinical decision support for medical management coverage decisions. The criteria provides a system for screening proposed medical care based on member-specific, best medical care practices and rule-based systems to match appropriate services to member needs based on clinical appropriateness. Criteria include:

- Acute care
- Adolescent psychiatry
- Adult chemical dependency and dual diagnosis
- Adult psychiatry
- Child psychiatry
- Durable medical equipment
- Geriatric psychiatry
- Home care
- Imaging
- ICF/IDD
- Long-term acute care
- Outpatient rehabilitation and chiropractic criteria
- Procedures adult/pediatric
- Rehabilitation
- Residential and community-based treatment
- Subacute nursing facility

Unicare Clinical Policy bulletins are used as secondary criteria if services are not found in InterQual. These are available for your review on our provider website.

If and when we use Amerigroup-developed review criteria, the following standards apply to the development of the criteria:

- Criteria are developed with involvement from appropriate providers with current knowledge relevant to the content of treatment guidelines under development
- Criteria are based on review of market practice and national standards/best practices
- Criteria are evaluated at least annually by appropriate, actively practicing physicians and other providers with current knowledge relevant to the criteria of treatment guidelines under review and updated as necessary; the criteria must reflect the names and qualifications of those involved in the development, the process used in development, and the timing and frequency at which the criteria will be evaluated and updated

Amerigroup utilization reviewers use these criteria as part of the preauthorization of scheduled admission, concurrent review, and discharge planning process to determine clinical appropriateness and medical necessity for coverage of continued hospitalization.

Copies of the criteria used in a case to make a clinical determination may be obtained by calling Provider Services. Providers may also submit their requests in writing to:

Medical Management  
Amerigroup Kansas, Inc.  
9225 Indian Creek Parkway, Building 32  
Overland Park, KS 66210

### **Peer-to-peer Discussion**

If the medical director denies coverage of the request, the appropriate notice of proposed action, including the member's appeal rights, will be mailed to the requesting provider, the member's PCP and/or attending physician and the member. You have the right to discuss this decision with our medical director by calling Provider Services.

### **10.7 Medical Advisory Committee**

Amerigroup has established a Medical Advisory Committee (MAC) to:

- Assess levels and quality of care provided to members
- Recommend, evaluate and monitor standards of care
- Identify opportunities to improve services and clinical performance by establishing, reviewing and updating clinical practice guidelines based on review of demographics and epidemiologic information to target high-volume, high-risk and problem-prone conditions
- Oversee the peer review process
- Conduct network maintenance through the credentialing/recredentialing process
- Advise the health plan administration in any aspect of the health plan policy or operation affecting network providers or members
- Approve and provide oversight of the peer review process, the Quality Management Program and the Utilization Review Program
- Oversee and make recommendations regarding health promotion activities
- Use an ongoing peer review system to:
  - Monitor practice patterns
  - Identify appropriateness of care

- Improve risk prevention activities
- Approve clinical protocols/guidelines
- Review clinical study design and results
- Develop action plans/recommendations regarding clinical quality improvement studies
- Consider/act in response to provider sanctions
- Provide oversight of Credentialing Committee decisions to credential/recredential providers
- Approve credentialing/recredentialing policies and procedures
- Oversee member access to care
- Review and provide feedback regarding new technologies
- Approve recommendations from subordinate committees

### **10.8 Credentialing**

Credentialing is an industry-standard, systemic approach to the collection and verification of an applicant's professional qualifications. This approach includes a review of relevant training, licensure, certification and/or registration to practice in a health care field, as well as academic background.

The credentialing process evaluates the information gathered and verified and includes an assessment of whether the applicant meets certain criteria relating to professional competence and conduct. We use current NCQA Standards and Guidelines for the Accreditation of Managed Care Organizations, as well as state-specific requirements for the credentialing and recredentialing of licensed independent providers and organizational providers with whom we contract. This process is completed before a practitioner or provider is accepted for participation in the Amerigroup network.

### **10.9 Credentialing Requirements**

To become a participating Amerigroup provider, you must hold a current, unrestricted license issued by the state. You must also comply with the Amerigroup credentialing criteria and submit all additionally requested information. A complete Kansas State Credentialing Application (practitioners) or an Amerigroup Ancillary/Facility Application and all required attachments must be submitted to initiate the process.

Amerigroup is one of over 600 participating health plans, hospitals and health care organizations that currently utilize the Council for Affordable Quality Healthcare (CAQH) Universal Provider Data Source (UPD) for gathering credentialing data for physicians and other health care professionals. Under this program, practitioners use a standard application and a common database to submit an electronic application. The Kansas Department of Health and Environment (KDHE) has adopted the CAQH practitioner application for medical and vision services practitioners.

Behavioral health, nursing facility, home- and community-based services (HCBS) providers and facility credentialing applications are not included in the CAQH UPD. These applicants should request an Amerigroup credentialing application by calling our Network Development team at 1-888-821-1108 or visiting [providers.amerigroup.com/KS](http://providers.amerigroup.com/KS).

### **10.10 Credentialing Procedures**

We use a Credentialing Committee comprised of licensed practitioners to review credentialing and recredentialing applicants, delegated groups and sanction activity related to existing network participants. The committee is also responsible for the creation and regular review of all policies and procedures relevant to the credentialing program.

We revise our credentialing policy periodically and no less frequent than annually based on input from:

- Credentialing Committees



- Health plan medical director
- Chief medical officer
- State and federal requirements

By signing the application, providers must attest to the accuracy of their credentials. If there are discrepancies between the application and the information obtained during the external verification process, the Amerigroup Credentialing department will investigate them. Discrepancies may be grounds for our denial of network participation or the termination of an existing contractual relationship.

Practitioners and providers will be notified by telephone or in writing if any information obtained during the process varies substantially from what was submitted.

The following elements are reviewed in the course of credentialing. Most of these elements are also included at the time of recredentialing:

1. Board Certification. Acceptable sources of verification include but are not limited to:
  - American Medical Association Provider Profile
  - American Osteopathic Association
  - American Board of Medical Specialties
  - American Board of Podiatric Surgery
  - American Board of Podiatric Orthopedics and Primary Podiatric medicine
2. Education and Training. Education and training will be verified for all practitioners at the time of initial credentialing. Acceptable sources of verification include but are not limited to:
  - Board certification
  - State-licensing agency
  - Educational institution
3. Work History. A full work history, documenting at least the prior five years, must be submitted at the time of practitioner credentialing. Any gaps in work history greater than six months must be explained in written format.
4. Hospital Affiliations and Privileges. Network Practitioners must have clinical privileges, as appropriate to their scope of practice, in good standing at an Amerigroup network hospital.
5. State Licensure or Certification. Initial credentialing applicants must have a current, legal state license or certification. This information will be verified by referencing data provided to us by the state via:
  - Roster
  - Telephone
  - Written verification
  - Internet
6. Enforcement Administration (DEA) Number. Initial practitioner applicants must provide their current DEA numbers to Amerigroup for verification. State controlled substance certificates, when applicable, will also be queried for verification.
7. Evidence of Professional and General Liability Coverage. Amerigroup will verify practitioner and provider malpractice coverage at the time of initial credentialing. A copy of the malpractice face sheet will provide evidence of coverage. In addition, an attestation that includes the following information may be used:
  - Name of the carrier

- Policy number
- Coverage limits
- Effective and expiration dates of such malpractice coverage

As a practitioner or a provider, you must maintain professional and general liability insurance in specified amounts in accordance with your Amerigroup contract.

8. Professional Liability Claims History. Initial credentialing applicants will be asked to provide a full professional liability claims history. This information will be assessed, along with a query of the National Practitioner's Data Bank (NPDB).
9. CMS Sanctions. All initial credentialing practitioner and provider applicants must not have any sanctions by Medicare/Medicaid. This information is verified by accessing the NPDB or the Office of the Inspector General (OIG).
10. Disclosures — Attestation and Release of Information. All initial credentialing applicants must respond to questions, including within the application regarding the following:
  - Reasons for being unable to perform the essential functions of the position with or without accommodation
  - History or current problems with chemical dependency, alcohol or substance use
  - History of license revocations, suspension, voluntary relinquishment, probationary status or other licensure conditions or limitations
  - History of conviction of any criminal offense other than minor traffic violations
  - History of loss or limitation of privileges or disciplinary activity, including denial, suspension, limitation, termination or nonrenewal of professional privileges
  - History of grievances or adverse action reports filed with a local, state or national professional society or licensing board
  - History of refusal or cancellation of professional liability insurance
  - History of suspension or revocation of a DEA or CDS certificate
  - History of any Medicare/Medicaid sanctions

Applicants must also provide a/an:

- Attestation of the correctness and completeness of the application
- Explanation in writing of any identified issues
- Disclosure of Ownership: The Centers for Medicare & Medicaid Services require Amerigroup to obtain certain information about the ownership and control of entities with which we contract for services for federal employees or federal health plans. This form is required for participation in the Amerigroup network. All individuals and entities included on the form must be clear of any sanctions by Medicare/Medicaid.

**Indian Health Services/Tribal Providers credentialing exceptions: we do not require Disclosure of Ownership forms from these providers.**

11. License History. The appropriate state-licensing board/agency is queried, along with the National Practitioner Databank (NPDB) as part of the credentialing process.

### **10.11 Recredentialing**

Recredentialing is required every three years by NCQA. Amerigroup will perform recredentialing at least every 36 months if not sooner. Network practitioners and providers will receive requests for recredentialing applications and supporting documentation in advance of the 36-month anniversary of their original

credentialing or last credentialing cycle. Information from quality improvement activities and member complaints will be assessed, along with assessments and verifications listed above.

#### **10.12 Rights of Providers During Credentialing/Recredentialing Processes**

You can request a status of your application through:

- Telephone
- Fax
- Mail

You have the right to:

- Review information submitted to support your credentialing application
- Explain information obtained that may vary substantially from what you provided
- Provide corrections to any erroneous information submitted by another party (you can do this by submission of a written explanation or by appearance before the Credentialing Committee)

The Amerigroup medical director has authority to approve clean files without input from the Credentialing Committee; all files not designated as clean will be sent to the Credentialing Committee for review and a decision regarding network participation.

We will inform you of the Credentialing Committee's decision in writing within 45 days. If your participation is denied, you can appeal this decision in writing within 30 days of the date of the denial letter.

#### **10.13 Organizational Providers**

Your signature on the application attests that you agree to the assessment requirements. The following providers require assessments:

- Hospitals
- Home health agencies
- Skilled nursing facilities
- Nursing homes
- Ambulatory surgical centers
- Behavioral health facilities

The following steps are included in the Amerigroup Organizational Provider Credentialing process:

- A review and primary source verification of a current copy of the state license
- A review of any restrictions to a license are investigated and could impact your participation in the network
- A review and primary source verification of any Medicare or Medicaid sanctions
- A review and verification of accreditation by one of the following when required:
  - The Joint Commission (formerly JCAHO)
  - Accreditation Association for Ambulatory Health Care
  - American Association of Ambulatory Surgical Facilities
  - American Academy of Sleep Medicine
  - American Board for Certification in Orthotics, Prosthetics and Pedorthics
  - Commission on Accreditation of Rehabilitation Facilities
  - Community Health Accreditation Program
  - Continuing Care Accreditation Commission
  - College of American Pathologists
  - Accreditation Commission for Home Care
  - American College of Radiology
  - Council on Accreditation

- Commission for the Accreditation of Birth Centers
- Board Certification/Accreditation International
- Commission on Accreditation for Home Care, Inc.
- Healthcare Facilities Accreditation Program (formerly AOA Hospital Accreditation Program)
- Intersocietal Accreditation Commission (CMS approved to handle MIPPA accreditation)
- Det Norske Veritas (DNV) Healthcare, Inc. NIAHO Hospital Accreditation Program

If your facility, ancillary or hospital is not accredited, a copy of a recent state or CMS review may be submitted in lieu of performing an onsite review. If there is no current accreditation or a recent state or CMS review, Amerigroup will perform an onsite review.

Evidence of malpractice insurance, in amounts specified in the provider contract and in accordance with Amerigroup policy, must also be included at the time of contracting/credentialing.

Amerigroup will track a facility's/ancillary's reassessment date and reassess every 36 months or sooner as applicable. The requirements for recredentialing are the same for reassessment as they are for the initial assessment.

The organizational provider or ancillary will:

- Be notified either by telephone or in writing if any information obtained in support of the assessment or reassessment process varies substantially from the information submitted
- Have the right to review the information submitted in support of the assessment process and to correct any errors in the documentation

#### **10.14 Delegated Credentialing**

Provider groups with strong credentialing programs that meet Amerigroup credentialing standards may be evaluated for delegation. As part of this process, Amerigroup will conduct a predelegation assessment of a group's credentialing policy and program, as well as an on-site evaluation of credentialing files. A passing score is considered to be an overall average of 90 percent compliance. If deficiencies are identified, the group is expected to submit an acceptable corrective action plan within 30 days of receipt of the audit results. If there are serious deficiencies, we will deny the delegation or will restrict the level of delegation.

We may waive the need for the predelegation onsite audit if the group's credentialing program is NCQA-certified for all credentialing and recredentialing elements.

Amerigroup is responsible for ongoing oversight of any delegated credentialing arrangement and will schedule appropriate reviews. The reviews are held at least annually.

#### **10.15 Peer Review**

We continuously monitor the quality and appropriateness of care of our practitioner and provider network through peer review.

Peer review responsibilities are to:

- Participate in the established peer review system
- Review and make recommendations regarding individual provider peer review cases
- Work in accordance with the executive medical director

If an investigation of a member grievance results in concern regarding your compliance with community standards of care or service, all elements of peer review will be followed.

We apply dissatisfaction severity codes and levels of severity to quality issues. Peer review includes investigation of physician actions by the medical director.

The medical director:

- Assigns a level of severity to the grievance
- Invites the cooperation of the physician
- Consults with and informs the MAC and Peer Review Committee
- Informs the physician of the committee's decision, recommendations, follow-up actions and/or disciplinary actions to be taken

We report outcomes to the appropriate internal and external entities that include the Quality Management Committee.

The peer review process is a major component of the MAC monthly agenda. The peer review policy is available upon request.

## **APPENDIX A – FORMS**

The following forms and more are available for download at [providers.amerigroup.com/KS](http://providers.amerigroup.com/KS). To request hard copies of these forms, call our Provider Services team.

### **Behavioral Health Coordination of Care**

- BH Authorization to Release Information
- Request for Authorization – Psychological Testing
- Request for Authorization – Neuropsychological Testing
- Outpatient Treatment Report FORM C
- Coordination of Care Form – BH Provider
- Coordination of Care Form – PCP

### **Cost Containment**

- Refund Notification

### **Encounters**

- Family Practice Encounter
- OB-GYN Encounter
- Internal Medicine Encounter
- Pediatric Encounter

### **Growth Hormone Clinical Management**

- Initial Request Adults
- Follow-up Adults
- Initial Request Pediatric and Adolescents
- Follow-up Pediatrics

### **Physical Therapy**

- Outpatient Therapy Initial Evaluation
- Outpatient Therapy Progress

### **Provider Grievance and Appeals**

- Claim Payment Appeal Submission
- Claim Correspondence

### **Referral and Claim Submissions**

- Precertification Request
- Pharmacy Prior Authorization Request
- Maternity Notification
- CMS-1500 (08-05)
- CMS-1450/UB-04

### **Screening Tools**

- Behavioral health screening tools

### **Training Verification**

- Training Verification form

**Update and Change Your Information**

- Change Information

**Well Care**

- Well Care (Birth–15 months)
- Well Care (18 months–12 years)
- Well Care (13 years–18 years)

**Other forms for sterilization services; advance directives; applications for the Women, Infants and Children Nutrition Program; and more are available at <https://www.kmap-state-ks.us/public/forms.asp>.**

## **APPENDIX B – BEHAVIORAL HEALTH INTEGRATED SERVICES**

### **OVERVIEW OF BEHAVIORAL HEALTH AT AMERIGROUP KANSAS**

The mission of Amerigroup Kansas is to coordinate the physical and behavioral health care of members, offering a continuum of targeted interventions, education and enhanced access to care to ensure improved outcomes and quality of life for KanCare members. Amerigroup Kansas works collaboratively with health care providers, including Community Mental Health Centers (CMHCs) and Community Developmental Disability Organization (CDDOs), as well as a variety of community agencies and resources to successfully meet the needs of members with Mental Health (MH) and Substance Use Disorders (SUDs), including those participating in waiver programs (e.g., SED, autism) and those with Intellectual/Developmental Disabilities (I/DD).

#### **Goals**

The goals of the Amerigroup Kansas Behavioral Health (BH) program are to:

- Ensure adequacy of service availability and accessibility to eligible members.
- Assist members and providers to utilize the most appropriate, least restrictive, medical and behavioral health care in the right place at the right time.
- Promote integration of the management and delivery of physical and behavioral health services to members.
- Achieve Amerigroup Kansas's quality initiatives including those related to HEDIS, NCQA and Kansas Department of Health and Environment (KDHE) performance requirements.
- Work with members, providers and community supports to provide tools and an environment that supports members towards their recovery goals.

#### **Objectives**

The objectives of the Amerigroup Kansas BH Program are to:

- Work with care providers to ensure the provision of medically necessary and appropriate care and services to our members at the least restrictive level of care, including inpatient care, alternative care settings and outpatient care, both in-and out-of-network.
- Provide high-quality case management and care coordination services designed to identify member needs and address them in a person-centered, holistic manner.
- Promote continuity and coordination of care among physical and behavioral health care practitioners.
- Maintain compliance with local, state and federal requirements, as well as accreditation standards.
- Utilize evidence-based guidelines and clinical criteria and promote the use of same in the provider community.
- Enhance member satisfaction by working with members in need to implement an individually-tailored and holistic support and care plan that allows the member to succeed at achieving his/her recovery goals.
- Enhance provider satisfaction and provider success by working to develop collaborative and supportive provider relationships built on mutually agreed upon goals, outcomes and incentives promote all health care partners are working together to achieve quality and recovery goals through education, technological supports and the promotion of recovery ideals.

Amerigroup Kansas-contracted providers deliver behavioral health and substance use disorder services in accordance with best practice guidelines, rules and regulations, and policies and procedures set forth by the KDHE. This includes mental health services such as psychiatric inpatient hospital services, 24-hour Psychiatric Residential Treatment Facilities (PRTFs), outpatient mental health services, case management, psychiatric rehabilitation services and behavioral health crisis services. Also included are Substance Use Disorder (SUD) treatment such as inpatient, residential and outpatient services.



## Recovery and Resiliency

“A personal process of overcoming the negative impact of a psychiatric disability despite its continued presence.”

— Townsend, W., S. Boyd, G. Griffin, and P. L. Hicks. 2000. Emerging best practices in mental health recovery. Columbus: Ohio Department of Mental Health.

“Recovery involves living as well as possible.”

—Slade, M. (2009) Personal Recovery and Mental Illness; A Guide for Mental Health Professionals. New York: Cambridge University Press.

“A process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential.”

— SAMHSA (2011)

Amerigroup Kansas believes physical and behavioral health services should be rendered in a manner that supports the recovery of persons experiencing mental illness and enhances the development of resiliency of those who are impacted by mental illness, serious emotional disturbance and/or substance use disorder issues. Recovery is a consumer-driven process in which consumers find their paths to work, learn and participate fully in their communities. Recovery is the ability to live a fulfilling and productive life despite the continued presence of a disability.

The Substance Abuse and Mental Health Services Administration (SAMHSA) has released a consensus statement on mental health recovery. The components listed in this consensus statement are reflective of our desire that all behavioral health services be delivered in a manner that promotes individual recovery and builds resiliency. The ten fundamental components of recovery as elucidated by SAMHSA include:

1. Self-direction: Consumers lead, control, exercise choice over and determine their own path of recovery by optimizing autonomy, independence and control of resources to achieve a self-determined life. By definition, the recovery process must be self-directed by the individual, who defines his or her own life goals and designs a unique path towards those goals.
2. Individualized and Person-centered: There are multiple pathways to recovery based on an individual's unique strengths and resiliency, as well as his or her needs, preferences, experiences (including past trauma) and cultural background in all of its diverse representations. Individuals also identify recovery as being an ongoing journey and an end result, as well as an overall paradigm for achieving wellness and optimal mental health.
3. Empowerment: Consumers have the authority to choose from a range of options and to participate in all decisions — including the allocation of resources — that will affect their lives and are educated and supported in so doing. They have the ability to join with other consumers to collectively and effectively speak for themselves about their needs, wants, desires and aspirations. Through empowerment, an individual gains control of his or her own destiny and influences the organizational and societal structures in his or her life.
4. Holistic: Recovery encompasses an individual's whole life, including mind, body, spirit and community. Recovery embraces all aspects of life, including housing, employment, education, mental health and health care treatment and services, complementary and naturalistic services (e.g., recreational services, libraries, museums, etc.), addictions treatment, spirituality, creativity, social networks, community participation and family supports as determined by the person. Families, providers, organizations, systems, communities and society play crucial roles in creating and maintaining meaningful opportunities for consumer access to these supports.

5. **Nonlinear:** Recovery is not a step-by-step process but one based on continual growth, occasional setbacks and learning from experience. Recovery begins with an initial stage of awareness in which a person recognizes that positive change is possible. This awareness enables the consumer to move on to fully engage in the work of recovery.
6. **Strengths-based:** Recovery focuses on valuing and building on the multiple capacities, resiliencies, talents, coping abilities and inherent worth of individuals. By building on these strengths, consumers leave stymied life roles behind and engage in new life roles (e.g., partner, caregiver, friend, student, and employee). The process of recovery moves forward through interaction with others in supportive, trust-based relationships.
7. **Peer Support:** Mutual support — including the sharing of experiential knowledge and skills and social learning — plays an invaluable role in recovery. Consumers encourage and engage other consumers in recovery and provide each other with a sense of belonging, supportive relationships, valued roles and community.
8. **Respect:** Community, systems and societal acceptance and appreciation of consumers — including protecting their rights and eliminating discrimination and stigma — are crucial in achieving recovery. Self-acceptance and regaining belief in one's self are particularly vital. Respect ensures the inclusion and full participation of consumers in all aspects of their lives.
9. **Responsibility:** Consumers have a personal responsibility for their own self-care and journeys of recovery. Taking steps towards their goals may require great courage. Consumers must strive to understand and give meaning to their experiences and identify coping strategies and healing processes to promote their own wellness.
10. **Hope:** Recovery provides the essential and motivating message of a better future — that people can and do overcome the barriers and obstacles that confront them. Hope is internalized but can be fostered by peers, families, friends, providers and others. Hope is the catalyst of the recovery process.

Resiliency is a dynamic developmental process especially for children and youth (and their families) that encompasses positive adaptation and is manifested by traits of self-efficacy, high self-esteem, maintenance of hope and optimism within the context of significant adversity.

Services that are provided to children and youth with serious emotional disturbances and their families are best delivered based on the System of Care Values and Principles that are endorsed by the SAMHSA and the Center for Mental Health Services (CMHS). Services should be:

- Child-centered and family focused with the needs of the child and family dictating the types and mix of services provided
- Community-based with the focus of services as well as management and decision making responsibility resting at the community level
- Culturally competent with agencies, programs, and services that are responsive to the cultural, racial, and ethnic differences of the populations they serve.
- The guiding principles of a system of care include:
  - Children should have access to a comprehensive array of services that address the child's physical, emotional, social, educational and cultural needs.
  - Children should receive individualized services in accordance with their unique needs and potential, which is guided by an individualized service plan.
  - Children should receive services within the least restrictive, most normative environment that is clinically appropriate.
  - Children should receive services that are integrated, with linkages between child-serving agencies and programs and mechanisms for planning, developing and coordinating services.

- Children should be provided with case management or similar mechanisms to ensure that multiple services are delivered in a coordinated, therapeutic manner and adapted in accordance with the changing needs of the child and family.
- Children should receive services without regard to race, religion, national origin, sex, physical disability or other characteristics.

## GENERAL PROVIDER INFORMATION

### How to Become a Behavioral Health Provider on the Amerigroup Kansas Network

Please see our credentialing information in this provider manual. If you have questions about the Amerigroup Kansas credentialing process before joining our network, call our Network Development team at 1-888-821-1108. If you are being recredentialed, you will receive a packet of instructions and contact information for questions or concerns.

Amerigroup Kansas believes the success of providers is necessary to achieve our goals. We are committed to supporting and working with qualified providers to ensure we jointly meet quality and recovery goals. Such commitment also includes:

- Improving communication of the clinical aspects of BH care to improve outcomes and recovery.
- Supporting providers in delivering integrated, coordinated physical and BH services to meet the needs of the whole person
- Precertification rules, referrals, claims and payment processes to help providers reduce administrative time and focus on the needs of members
- Using reasonable precertification requirements that minimize administrative burden

### Provider Types and Specialties

Please refer to our Behavioral Health provider type/specialty taxonomy crosswalk at [providers.amerigroup.com/KS](http://providers.amerigroup.com/KS) under the menu item *Reference & Training* for reimbursement information by provider type and specialty codes recognized.

### Border City Providers

Some cities outside of the state of Kansas but within 50 miles of the Kansas border are designated as “Border Cities” (Please see the KMAP Provider Manual at [www.kmap-state-ks.us](http://www.kmap-state-ks.us) for more details). Eligible providers practicing outside of Kansas but within a border city designated area may enroll with Amerigroup for the provision of services to KanCare members. Such enrollment will not require Kansas licensure but the provider must meet the licensing requirements of the state in which they are providing the services.

### Substance Use Covered Services

T-XIX Funded Services for T-XIX Members		
Service	State Plan	Waiver
Level I – Outpatient		
Individual Counseling	X	X
Group Counseling	X	X
Level II: Intensive Outpatient Treatment/Partial Hospitalization		
Intensive Outpatient	X	X
Level III - Residential/Inpatient Treatment		
3.1 Reintegration	X	X
3.5 Intermediate	X	X
3.7D - Acute detoxification	X	X
Auxiliary Services		
Assessment/Referral	X	X

Medicaid Case Management	X	X
Peer Support	X	X
Crisis Intervention	X	X

- Court ordered/civil commitment services (subject to medical necessity)

### Mental Health Covered Services

T-XIX Funded Mental Health Services	T-XIX Members	
	State Plan Only Members	SED Waiver
Outpatient Therapy and Medication Management Services		
Evaluation and Assessment	X	X
Testing	X	X
Individual Therapy	X	X
Family Therapy	X	X
Group Therapy	X	X
Medication Management	X	X
Medication Administration	X	X
Case Consultation	X	X
Rehabilitation Services (Subject to functional eligibility requirements)		
Community Psychiatric Support and Treatment	X	X
Psychosocial Rehabilitation	X	X
Peer Support	X	X
Crisis Intervention	X	X
Targeted Case Management (Not covered for CHIP members)		
Kan-be-Healthy		
Evaluation and Assessment	X	X
Service Plan Development	X	X
SED Waiver Services		
Parent Support and Training		X
Independent Living/Skills Building		X
Short Term Respite Care*		X
Wrap Around Facilitation		X
Professional Resource Family Care*		X
Attendant Care Services		X
Attendant Care	X	
Case Consultation	X	X

\*These services are not covered for members who are in foster care.

PRTFs provide intensive inpatient mental health services to children and youth that meet admission criteria. The multi-disciplinary consultation team is convened to consider supports and interventions that have previously been in place identify supports and interventions that have not been in place and provide recommendations to determine if the child and youth is best served in a community or inpatient setting. Amerigroup will apply medical necessity criteria upon or prior to admission.

### Enhanced Respite Care

Amerigroup Kansas offers enhanced respite care services for members participating in the Autism and Developmental Disability waiver programs as follows:

- Autism Waiver – 24 additional hours per year of Autism respite services paid at the 15-minute unit rate
- Developmental Disability Waiver – 15 extra days of overnight respite care and three extra days of Personal Care Services (PCS) per year

The benefit is not offered to:

- Members living alone
- Members living in ICF/IDD, assisted living and nursing facilities, group homes or similar settings

### **Services Requiring Precertification**

Services require precertification and begin after all covered services have been utilized. The following services require precertification:

- Inpatient Psychiatric and Substance Abuse Treatment
- Psychiatric Residential Treatment Facility (PRTF) Treatment
- Electro-convulsive Therapy (ECT)
- Nursing facilities for mental health for eligible members (under age 21, over age 65)
- Autism Waiver Services
  - Consultative Clinical and Therapeutic Services
  - Intensive Individual Supports
  - Family Adjustment Counseling
  - Interpersonal Communication Therapy
  - Parent Support and Training
- SED Waiver Services
  - Parent Support and Training
  - Independent Living/Skills Building
  - Short Term Respite Care
  - Wraparound Facilitation
  - Attendant Care for SED Waiver Participants
  - Professional Resource Family Care
- Enhanced respite services (Developmental Disability, Autism Waiver)

These services require notification/registration prior to initiation of a new episode of care. Some services require prior authorization for additional services beyond a pre-determined limit. These are as follows:

- SUD Services (requires notification/pre-authorization in KCPC):
  - Level I – 60 hours over 6 months
  - Level II – 45 days over 15 weeks
  - Level III.1 – 30 days
  - Level III.3 and III.5 – 14 days
  - SUD Auxiliary Services – (Assessment and Referral, Medicaid Case Management, SUD Peer Support, Crisis Intervention) – These services require notification in KCPC
- Mental Health Services (unit = 15 minutes):
  - Psychological/Neuropsychological Testing – 6 hours/year
  - Community Psychiatric Support and Treatment (CPST) – 144 units (36 hours) per calendar year
  - Targeted Case Management – 96 units (24 hours) per calendar year
  - Case Conference – 8 hours (32 units)/year
  - Peer Support – 250 hours (1,000 units)/year
  - Crisis Intervention/Stabilization – Re-evaluation required by a QMHP every 72 hours
  - Admission Evaluation – 5 sessions/year – Does not require notification or authorization from Amerigroup

## Services Not Included

The following services are not covered by Amerigroup Kansas, but may be covered under Fee-For-Service for T-XIX eligible members (please see the KMAP website at [www.kmap-state-ks.us](http://www.kmap-state-ks.us)):

- State mental hospitals, or other institutions for mental diseases (IMD), for members over age 21 or under age 65
- State hospitals for people with intellectual or developmental disabilities that are also public intermediate care facilities for people with intellectual or developmental disabilities (ICFs/IDD)
- Institution for mental diseases (IMD) for members over age 21 or under age 65
- School-based services (with some exceptions), Early Intervention Services ordered through an Individual Education Plan (IEP) or Independent Family Services Plan (IFSP), Local Education Agencies (LEA's), Head Start Facilities, Part C of the Individuals With Disabilities Education (IDEA) Act
- Laboratory services performed by the Kansas Department of Health and Environment
- Nursing facilities for mental health for members over age 21 or under age 65
- Prevention services provided under the Substance Abuse Prevention and Treatment (SAPT) Block Grant

## Member Records and Treatment Planning

Member records must meet the following standards and contain the following elements, if applicable, to permit effective service provision and quality reviews:

- Information related to the provision of appropriate services to a member must be included in his or her record to include documentation in a prominent place whether there is an executed declaration for mental health treatment.
- For members in the population, a comprehensive assessment that provides a description of the consumer's physical and mental health status at the time of admission to services. This comprehensive assessment covers:
  - **A psychiatric assessment that includes:**
    - Description of the presenting problem
    - Psychiatric history and history of the member's response to crisis situations
    - Psychiatric symptoms
    - Multi-axial diagnosis using the most current edition of Diagnostic and Statistical Manual of Mental Disorders (DSM)
    - Mental status exam
    - History of alcohol and drug abuse
  - **A medical assessment that includes:**
    - Screening for medical problems
    - Medical history
    - Present medications
    - Medication history
  - **A substance use assessment that includes:**
    - Frequently used over-the-counter medications
    - Alcohol and other drugs and history of prior alcohol and drug treatment episodes
    - The history should reflect impact of substance use in the domains of the community functioning assessment
  - **A community functioning assessment or an assessment of the member's functioning in the following domains:**
    - Living arrangements, daily activities (vocational/educational)
    - Social support
    - Financial
    - Leisure/recreational
    - Physical health

- Emotional/behavioral health
  - An assessment of the member's strengths, current life status, personal goals and needs
- A patient-centered support and care plan, which is based on the psychiatric, medical, substance use and community functioning assessments listed above, must be completed for any member who receives behavioral health services.
- The support and care plan must be completed within the first 14 days of admission to behavioral health services and updated every 90 days, or more frequently as necessary based on the member's progress towards goals or a significant change in psychiatric symptoms, medical condition and/or community functioning.
- There must be documentation in every case that the member and, as appropriate, his or her family members, caregivers or legal guardian, participated in the development and subsequent reviews of the treatment plan.
- For providers of multiple services, one comprehensive treatment/care/support plan is acceptable as long as at least one goal is written and updated as appropriate for each of the different services that are being provided to the member.
- The treatment/support/care plan must contain the following elements:
  - Identified problem(s) for which the member is seeking treatment
  - Member goals related to problem(s) identified, written in member-friendly language
  - Measurable objectives to address the goals identified
  - Target dates for completion of objectives
  - Responsible parties for each objective
  - Specific measurable action steps to accomplish each objective
  - Individualized steps for prevention and/or resolution of crisis, which includes identification of crisis triggers (situations, signs and increased symptoms); active steps or self-help methods to prevent, de-escalate or defuse crisis situations; names and phone numbers of contacts that can assist the member in resolving crisis; and the member's preferred treatment options, to include psychopharmacology, in the event of a mental health crisis
  - Signatures of the member as well as family members, caregivers or legal guardian as appropriate
- Progress notes are written to document status related to goals and objectives indicated on the treatment plans.
  - Correspondence concerning the member's treatment and signed and dated notations of telephone calls concerning the member's treatment.
  - A brief discharge summary must be completed within 15 calendar days following discharge from services or death.
  - Discharge summaries for psychiatric hospital and residential treatment facility admissions that occur while the member is receiving behavioral health services.
- Amerigroup Kansas will monitor provider compliance with treatment plan requirements through medical record reviews or other measures. Providers who do not meet the goal of 100-percent compliance with treatment plan requirements may be subject to corrective action and asked to submit a plan for meeting the 100-percent requirement.

### **Adverse Incident Reporting**

Adverse occurrence (e.g. sentinel events, major critical events) reports must be made by each participating provider to all appropriate agencies as required by licensure and state and federal laws within the specified time frames required immediately following the event. Within 24 hours, these events must be reported into the Adverse Incident Reporting system (AIR). See section on Critical Incident Reporting and Management for more information. Examples of adverse occurrences include, but are not limited to:

- Treatment complications (including medication errors and adverse medication reactions)
- Accidents or injuries to a member

- Morbidity
- Suicide attempts
- Death of a consumer
- Allegations of physical abuse, sexual abuse, neglect and mistreatment, and/or verbal abuse
- Use of isolation, mechanical restraint or physical holding restraint
- Any clear and serious breach of accepted professional standards of care that could endanger the safety or health of a member or members

### **Psychotropic Medications**

Providers must inform all members being considered for prescription of psychotropic medications of the benefits, risks and side effects of the medication, alternate medications and other forms of treatment. The medical record is expected to reflect such conversations as having occurred.

Members on psychotropic medications may be at increased risk for various disorders. As such it is expected that providers are knowledgeable about side-effects and risks of medications and regularly inquire about and seek for any side-effects from medications. This especially includes:

1. Follow-up to inquire about suicidality or self-harm in children placed on anti-depressant medications as per FDA and APA guideline
2. Regular and frequent weight checks and measurement of abdominal girth especially for those on antipsychotics or mood stabilizers
3. Glucose tolerance test or hemoglobin A-1C tests especially for those members on antipsychotics or mood stabilizers
4. Triglyceride and cholesterol checks especially for those members on antipsychotics and mood stabilizers
5. ECG checks for members placed on medications with risk for significant QT-prolongation.
6. Ongoing checks for movement disorders related to antipsychotic use and psychotic disorders.

Guidelines for such testing and follow-up are provided by the American Psychiatric Association amongst others. Summary guidelines are referenced in Amerigroup Kansas's CPGs which can be found at [providers.amerigroup.com/KS](http://providers.amerigroup.com/KS). While the prescriber is not expected to personally conduct all of these tests, the prescriber is expected to ensure that these tests occur where indicated and to initiate appropriate interventions to address any adverse results. These tests and the interventions are expected to be documented in at minimum the medical record for the member.

## **THE AMERGROUP KANSAS UTILIZATION MANAGEMENT PROCESS**

### **Utilization Management Decision Making**

Amerigroup, as a corporation and as individuals involved in Utilization Management (UM) decisions, is governed by the following statements:

- UM-decision making is based only on appropriateness of care and service and existence of coverage.
- Amerigroup does not specifically reward practitioners or other individuals for issuing denial of coverage care. Decisions about hiring, promoting or terminating practitioners or other staff are not based on the likelihood or perceived likelihood that they support or tend to support denial of benefits.
- Financial incentives for UM decision-makers do not encourage decisions that result in underutilization or create barriers to care and service.

### **Our Behavioral Health Customer Service Staff**

Provider calls to our Provider Services Line during regular business hours are taken by our experienced team of Clinical Services Technicians (CSTs). CSTs assist providers with routine inquiries about member eligibility, benefits and claims or with referrals to network providers for your patients. If you are calling about



precertification for a service that requires precertification and clinical review, these requests are referred to a member of our clinical staff to initiate a review of the request.

Provider calls after business hours are taken by our Nurse HelpLine staff who will issue you a reference number for the precertification request. All requests for precertification will be reviewed by appropriate BH staff within decision and notification timeliness standards (see grid below, “Timeliness of Decisions on Requests for Precertification”).

### Behavioral Health Access To Care Standards

Amerigroup will make authorization determinations within timeframes that facilitate timely access to care per the standards outlined below. For this to occur, it is critical that Amerigroup receive all necessary clinical information in a timely manner.

Mental health	<ol style="list-style-type: none"> <li>1. Poststabilization: Within one hour from referral for poststabilization services (both inpatient and outpatient) in an emergency room</li> <li>2. Emergent: Within three hours for outpatient MH services and within one hour from referral for an emergent concurrent utilization review screen</li> <li>3. Urgent: 48 hours from referral for outpatient MH services and within 24 hours from referral for an urgent concurrent utilization review screen</li> <li>4. Planned Inpatient Psychiatric: Referral within 48 hours, assessment and/or treatment within five working days from referral</li> <li>5. Routine Outpatient: Referral within five days, assessment and/or treatment within nine workdays from referral and/or 10 workdays from previous treatment</li> </ol>
Substance Use Disorder (SUD) Services	<p><b><i>Emergent:</i></b> Treatment is considered to be an on-demand service and does not require precertification. Members are asked to go directly to emergency rooms for services if they are either unsafe or their conditions are deteriorating.</p> <p><b><i>Urgent:</i></b> Means a service need that is not emergent and can be met by providing an assessment within 24 hours of the initial contact, and services delivered within 48 hours from initial contact without resultant deterioration in the individual's functioning or worsening of his or her condition. If the Member is pregnant she is to be placed in the urgent category.</p> <p><b><i>Routine:</i></b> Means a service need that is not urgent and can be met by receiving an assessment within 14 calendar days of the initial contact, and treatment within 14 calendar days of the assessment without resultant deterioration in the individual's functioning or worsening of his or her condition.</p> <p><b><i>IV Drug Users:</i></b> If a Member has used IV drugs within the last six months, and he or she does not fall into the Emergent or Urgent categories because of clinical need, he or she should be placed in this category. Members who have utilized IV drugs within the last six months need to be seen for treatment within 14 calendar days of initial contact. There is not a time standard requirement for the assessment; nor is there an IV Drug User category in the KCPC.</p> <p>These members are categorized as routine but are to receive treatment within 14 days of their initial contact, not within 14 days of their assessment.</p>

## **Our Clinical Staff**

Amerigroup Kansas has assembled a highly trained and experienced team of clinical care managers, case managers, and support staff to provide high quality care management and care coordination services to KanCare members and to work collaboratively with you, our providers. All clinical staff are licensed and have experience requirements which generally include at least 4 years of prior clinical experience. Our BH Medical Director is board certified in psychiatry, licensed in Kansas and is certified in Addiction Medicine.

## **How to Provide Notification or Request Preauthorization**

- You may provide notification or request preauthorization for mental health services that require preauthorization via phone by calling 1-800-454-3730 24 hours/day, 7 days/week, 365 days/year. Please be prepared to provide clinical information in support of the request at the time of the call.
- You may request preauthorization via fax. Amerigroup Kansas approved fax forms can be obtained on our Provider Website at [www.providers.amerigroup.com/KS](http://www.providers.amerigroup.com/KS) . The Amerigroup Kansas BH fax numbers are:
  - Inpatient requests: 1-877-434-7578
  - Outpatient requests: 1-800-505-1193
- You may request precertification via the provider website at [providers.amerigroup.com/KS](http://providers.amerigroup.com/KS).
- If you are a SUD provider, you must utilize the Kansas Client Placement Criteria (KCPC) screening and assessment tool which is based on American Society of Addiction Medicine (ASAM) criteria. For information on using the KCPC system, please visit [providers.amerigroup.com/KS](http://providers.amerigroup.com/KS).

Note: All requests for precertification for psychological and neuropsychological testing beyond the six-hour initial limit should be submitted via fax at 1-800-505-1193 (See Provider Forms section). Psychological/neurological testing request forms can also be mailed to:

Behavioral Health Department  
Amerigroup Kansas, Inc.  
P.O. Box 62509  
Virginia Beach, VA 23466-2509

## **Amerigroup Kansas Clinical Criteria**

- In addition to utilizing the Kansas Definition of Medical Necessity (see below), Amerigroup Kansas utilizes clinical criteria to evaluate the medical necessity of requests for care and services as follows:
  - Mental Health – Behavioral Health Medical Policies and Clinical UM Guidelines
  - Substance Use Disorder – Kansas Client Placement Criteria (KCPC) which is based on American Society of Addiction Medicine (ASAM) Patient Placement Criteria
- Additional level of care criteria will be used for services not included in the Behavioral Health Medical Policies and Clinical UM Guidelines or KCPC ASAM criteria sets (e.g., HCMS waiver services). For more information about additional criteria in use by Amerigroup Kansas please visit [providers.amerigroup.com/KS](http://providers.amerigroup.com/KS).
- All criteria used by Amerigroup Kansas are approved by the Amerigroup Kansas Medical Advisory Committee and the Amerigroup National Medical Policy Committee.
- For information about how to access to Behavioral Health Medical Policies and Clinical UM Guidelines, please call the Amerigroup Provider Services Line.

For more information about the Behavioral Health Medical Policies and Clinical UM Guidelines, providers can refer to <https://providers.amerigroup.com/medicalpolicies>.

### **Behavioral Health Medical Necessity Determination and Peer Review**

- When a provider requests initial or continued precertification for a covered BH service, Amerigroup Kansas Utilization Managers obtain necessary clinical information and review it to determine if the request appears to meet applicable medical necessity criteria.
- If the information submitted does not appear to meet such criteria, the Utilization Manager submits the information for review by an Amerigroup Kansas BH Medical Director, or other appropriate practitioner, as part of the peer review process.
- The Amerigroup Kansas reviewer, or the requesting provider, may initiate a peer-to-peer conversation to discuss the relevant clinical information with the clinician working with the member.
- If an adverse decision is made by the Amerigroup reviewer without such a peer-to-peer conversation having taken place (as may occur when the provider is unavailable for review), the provider may request such a conversation within 2 business days of the issuance of the adverse decision. In this case, we will make a BH Medical Director, or other appropriate practitioner, available to discuss the case with the requesting provider. This conversation may result in the decision being upheld or changed.
- Members, requesting providers, and applicable facilities are notified of any adverse decision by Amerigroup Kansas within notification timeframes that are based on the type of care requested, and in conformance with regulatory and accreditation requirements.

### **Non-Medical Necessity Adverse Decisions (Administrative Adverse Decision)**

A request for precertification may result in an adverse decision for reasons other than a lack of medical necessity. Reasons for such an adverse decision may include:

- The notification of admission was late – Providers must notify Amerigroup Kansas within 24 hours, or the next business day, of any inpatient admission of an Amerigroup Kansas member.
- The provider failed to request precertification of a service that requires prior precertification.
- The member was ineligible on the date of service.
- The requested service/benefit was a noncovered service/benefit.
- The limit on the benefit has been reached.

### **Provider Appeals, Grievances and Payment Disputes**

If you did not receive a precertification for a requested service and think that this decision was in error, please see the sections within this provider manual that contain information and instructions on appeals, grievances and payment disputes.

### **Avoiding an Adverse Decision**

Most administrative adverse decisions result from nonadherence to or a misunderstanding of utilization management policies. Familiarizing yourself and your staff with notification and precertification policies and acting to meet those policies can eliminate the majority of these decisions. Other administrative adverse decisions result from misinformation about the member's status or the member's benefits. Such information is readily available from Amerigroup Kansas by calling 1-800-454-3750.

Adverse decisions of a medical nature are rare. Such adverse decisions usually involve a failure of the clinical information to meet evidenced-based, national guidelines. Amerigroup Kansas is committed to working with all providers to ensure that such guidelines are understood and to identify gaps for providers around meeting such guidelines. Peer-to-Peer conversations (between an Amerigroup medical director and the provider clinicians) are one way that Amerigroup Kansas is able to ensure the completeness and accuracy of the clinical information and provide a one-on-one communication about the guidelines as necessary. Medical record reviews are another way to ensure that clinical information is complete and accurate. Providers that are able to appropriately respond in a timely fashion to peer-peer and medical record requests are less likely to encounter dissatisfaction

with the utilization management process. Amerigroup Kansas is committed to ensuring a process that is quick and easy and will work with participating providers to ensure a mutually satisfying process where possible.

### **Reducing Risk to Members With Special BH or SUD Health Care Needs Through the Amerigroup Kansas Case Management/Care Coordination Process**

- When a member is identified as having special mental health and/or SUD needs requiring some type of intervention to reduce risk, Amerigroup Kansas utilizes the following strategies:
  - Inpatient Management – Moderate to high-risk hospitalized members
    - When “at risk” members are identified as part of the census management process, the UM staff works with provider discharge planners, Amerigroup Kansas's Transitional Care Coaches, and/or Amerigroup Case Managers to develop a discharge plan that maximizes the likelihood of the member making a successful transition back into the community. Key elements of the discharge plan include, but are not limited to:
      - Understanding the characteristics of each particular member (job, family, education, social activities, family background, prior service utilization, etc.)
      - In the case of rapid readmissions – an admission that occurs within 30 days of discharge from the same level of care:
        - What has worked in the past in helping this member to stay out of the hospital (e.g., medications, treatment plan, services and supports)?
        - What elements of the previous discharge plan did not work and need to be changed?
      - How do medical issues or complications impact the treatment plans?
      - What is the involvement of the family in the treatment process and how do the family and other social supports factor into the discharge plan?
      - Are follow-up appointments scheduled prior to discharge?
      - The BH Medical Director conducts daily UM rounds and participates in complex case rounds to assist in facilitating the member’s successful transition back into the community
  - Transitional Care – Moderate to high-risk hospitalized members
    - A Transitional Care Coach collaborates with the UM staff to work with members, their family caregivers, and, when appropriate, the hospital's discharge planning staff to develop a discharge plan. The plan may include:
      - Pre-transition contacts
      - Assisting the member with planning for follow-up care and ensuring that appointments are scheduled, transportation arranged, etc.
      - Post-discharge contacts
      - Medication reconciliation
      - "Red-flag" education for the member and family/caregiver, as appropriate, about potential problems or relapse triggers
      - Disease-specific interventions
    - Transitional Care is a short term intervention strategy with the goals of reducing the member's risk of re-admission and increasing the likelihood that he or she will make a successful transition back into the community.
  - Complex Case Management
    - Once a member is identified as having complex case management needs through identification methods outlined above, the Case Manager attempts to engage the member to conduct an assessment to determine the member's care management needs.
    - The Case Manager works with the member, as well as the member's family/caregiver, as appropriate, to identify goals that are expressed in member-friendly language.
    - The care plan includes interventions that are agreed upon to achieve the member's goals.

- The Case Manager also obtains input from the member's PCP and other specialty providers in developing the care plan.
- For members with mental health and/or SUD needs, the Case Managers ensures that all needed behavioral health and medical care needs are integrated in a holistic manner, by facilitating communication among treating providers and scheduling regular case conferences as required. The Case Manager may also utilize complex case rounds to obtain input on especially difficult integration issues.
- The Case Manager then monitors the member's progress, at regular intervals depending on the member's acuity, in meeting care plan goals. The Case Manager coordinates care and services with all treating providers, and assists the member with community resource referrals. Contacts with the member may be done telephonically, or through face-to-face contact, depending on the member's level of acuity.
- Case Management continues until the care plan goals have been substantially met or there is agreement with the member/family/caregiver, as appropriate, that further care management is not indicated.
- Amerigroup Kansas Disease Management Centralized Care Unit (DMCCU)
  - The needs of lower acuity members with mental health or substance use disorder needs may be met through the DMCCU through some combination of:
    - Lower acuity telephonic care management
    - Disease Management Programs (schizophrenia, major depression, bipolar disorder or substance use disorder)
    - Referrals to preventive services
    - Providing them with health promotion materials.

### **Behavioral Health Drug Utilization Review (DUR) Program**

Care Management Technologies (CMT) provides behavioral health prescriber outreach with a special focus on the seriously mentally ill. CMT identifies prescribing practices that deviate from evidence-based medicine. CMT evaluates patient-centric data from multiple sources to create an Integrated Health Profile for coordinating treatment among diverse clinical team members. CMT may contact you about specific patient information. The contact is intended to be informative and is in no way punitive. Please review information provided by CMT on behalf of your Amerigroup members. DUR programs have been shown to be effective at improving health care quality while reducing medical and/or pharmacy costs.

### **Post-Discharge Outreach**

Amerigroup providers are required to conduct outreach to all members discharging from inpatient care to encourage the member's attendance at follow-up appointments according to the all of the following KDHE standards:

- At least 85 percent of these outreach contacts must occur within 24 to 72 hours of discharge
- At least 90 percent must occur within one to seven days of discharge
- 95 percent must occur within one to 10 days of discharge

Amerigroup will require providers to maintain records of the results of such outreach efforts and will require reporting of this information to Amerigroup on a regular basis. Amerigroup will also conduct on-site audits of Member records on at least a quarterly basis.

Providers are also encouraged to use these outreach opportunities to ensure that discharged members/caregivers have been able to fill necessary prescriptions and have access to transportation for follow-up appointments. If members/caregivers need assistance with filling prescriptions, with transportation to their

appointments, or with appointment scheduling, they should be encouraged to contact the Amerigroup Member Services Line at 1-800-600-4441 for assistance.

### **Diversion Plans**

When clinically indicated, Amerigroup encourages providers conducting crisis assessments for members at risk for admission to higher levels of care (e.g., acute inpatient, PRTF) to carefully consider the opportunity for developing diversion plans, with appropriate member and family/caregiver involvement, to assist the member in safely achieving stabilization at a lower level of care.

The provider should contact the member/family/caregiver, as appropriate, as soon as possible following the diversion to offer needed outpatient services.

### **Crisis Assessments**

Providers delivering crisis assessments to members must initiate a follow-up contact within one business day to any member seen for or provided with any emergency service and not detained for inpatient care and treatment, to determine the need for any further services or referral to any services.

### **Clinical Practice Guidelines**

All providers have ready access to evidence-based clinical practice guidelines for a variety of behavioral health disorders commonly seen in primary care, including ADHD, Bipolar Disorder For Adults and Adolescents, Major Depressive Disorder, Schizophrenia and SUDs as well as evidence-based information on the use of psychotropic medications. Please see the provider website at [providers.amerigroup.com/KS](http://providers.amerigroup.com/KS).

### **Coordination of Behavioral Health and Physical Health Treatment**

- Amerigroup Kansas puts special emphasis on the coordination and integration of physical and behavioral health services, wherever possible. Key elements of the Amerigroup model of coordinated care include:
  - Ongoing communication and coordination between PCPs and specialty providers, including behavioral health (mental health and substance use) providers
  - Screening for co-occurring disorders, including:
    - Behavioral health screening by PCPs
    - Medical screening by behavioral health providers
    - Screening of mental health patients for co-occurring SUDs
    - Screening of consumers in substance use disorder treatment for co-occurring mental health and/or medical disorders
  - Screening tools for PCPs and behavioral health providers can be located at [providers.amerigroup.com/KS](http://providers.amerigroup.com/KS)
  - Referrals to PCPs or specialty providers, including behavioral health providers, for assessment and/or treatment for consumers with co-occurring disorders
  - Involving members, as well as caregivers and family members, as appropriate, in the development of patient-centered treatment plans; case management and disease management programs to support the coordination and integration of care between providers
- As an Amerigroup network provider, you are required to notify a member's PCP when a member first enters behavioral health care and anytime there is a significant change in care, treatment or need for medical services, provided that you have secured the necessary release of information. The minimum elements to be included in such correspondence are:
  - Patient demographics
  - Date of initial or most recent behavioral health evaluation
  - Recommendation to see PCP, if medical condition identified or need for evaluation by a medical practitioner has been determined for the member (e.g., EPSDT screen, complaint of physical ailments)

- Diagnosis and/or presenting behavioral health problem(s)
- Prescribed medication(s)
- Behavioral health clinician’s name and contact information (See Forms Section)

## **Training**

Amerigroup must monitor and ensure all participating providers that deliver Behavioral Health services provide relevant staff with training in accordance with KDHE requirements. As a contracted provider of Amerigroup, your organization is required to provide training to your staff as appropriate. Your organization is also responsible for complying with any updates in training requirements. Additionally, Amerigroup will implement measures to monitor compliance with training requirements.

## **Additional Training**

Amerigroup Kansas will present a series of quarterly training programs for PCPs and Behavioral Health providers on topics related to the coordination of behavioral health and physical health care. It is anticipated that these training events will include the opportunity for providers to obtain CME/CEU credit for participation. Please consult the Amerigroup Kansas Provider Website for a schedule of these training events.

## **Behavioral Health Consultations for Primary Care Providers**

Amerigroup will provide all contracted PCPs with the ability to consult with a Behavioral Health specialist. For more information about this and other Behavioral Health consultation resources please call the Amerigroup Kansas Provider Services Line at 1-800-454-3730.

## **SED Waiver**

The Serious Emotional Disturbance (SED) waiver Program is designed to expand Medicaid services for children between 4 and 17 at risk of admission to a State Mental Health Hospital (SMHH). Additionally, individuals between the ages of 18 and 22 may be eligible for HCBS SED waiver services if intensive community based services have been in place and continually provided to the individual for at least 6 months prior to the date of application for waiver services.

Services offered under the HCBS SED waiver include:

- Parent support and training
- Independent living/skills building
- Short-term respite care
- Wraparound facilitation, which is led by a community mental health provider who works with the member and the member’s extended family to create an individual plan of care
- SED waiver personal care services

Providers must meet state eligibility and training criteria for Amerigroup Kansas. Service limits apply.

## **Autism Waiver**

The Autism waiver for children with autism is designed for Medicaid-eligible children from zero to five years of age (at the time of the application) who are at risk of admission to an inpatient psychiatric facility for individuals under 21 years of age. The waiver provides opportunities for children to receive intensive early intervention treatment and their primary caregivers to receive assistance and support.

Service offered under the HCBS Autism Waiver are:

- Consultative clinical and therapeutic services (provided by an autism specialist)
- Family adjustment counseling
- Intensive individual supports
- Interpersonal communication therapy

- Parent support and training
- Respite care

See Covered Services above for coverage limits. Providers must meet state eligibility and training criteria. All waiver services must be preauthorized by Amerigroup Kansas.



## APPENDIX C – PROCEDURES FOR SKILLED NURSING FACILITIES/NURSING HOMES

For the convenience of Nursing Facility (NF) providers, we consolidated some very specific information related to the unique services and issues faced by the industry, here. However, all other sections of our Provider Manual not described here are also applicable, such as credentialing, recredentialing, quality programs, etc. and are the responsibility of the NF provider, as applicable, based on the scope of services as determined by the provider's licensure.

### Member Benefit Overview

- Amerigroup members are entitled to room, board and all per diem services in an NF based on medical necessity.
  - Medical necessity for a short term placement is determined by Amerigroup using established criteria for placement.
    - The NF should request precertification, sometimes referred to as Prior Authorization (PA) within certain Kansas reference documents, for all such placements that may occur through a discharge from a hospital, member's home, etc.
  - Medical necessity for long-term placements is determined through the state clinical level of care process.
    - Once an individual is approved for clinical and financial eligibility, they will be enrolled in a participating KanCare managed care organization as an institutional NF member.
- Members are entitled to medical and nonmedical leaves of absence (reserve days).
  - Members are allowed up to 10 days per confinement for reservation of a bed if member is admitted to an acute care facility.
  - Members are allowed up to 21 days per admission for reservation of a bed if member is admitted to a state mental hospital, private psychiatric hospital, or a psychiatric ward in an acute care facility.
  - Members are allowed a non-medical leave of absence from an NF with a maximum of 18 days per calendar year.

### Member Eligibility

- Reimbursement is contingent upon proof of member eligibility.
- To check eligibility, please use the Amerigroup eligibility lookup tool to get the most up to date member information. Log in to our provider self-service site, select **Eligibility & Panel Listings** in the *Tools* menu and select **Eligibility**.
- You can also call our Provider Services team to verify member eligibility.
- Beginning with dates of service June 1, 2016, and after, we will require providers to submit a copy of the *Notification of Nursing Facility Admission/Discharge* form (MS-2126) to us for all new admissions, so that we may ensure proper payment of claims. If KDHE has not determined that the member meets both functional eligibility and financial eligibility for nursing facility level of care, we are unable to pay the claim.

### Member Liability

Medicaid should be the payer of last resort. Amerigroup will ensure Medicare skilled NF benefits are exhausted prior to utilizing Medicaid. Amerigroup will assist the facility in convening a discussion with the member and/or responsible party and/or state staff, Adult Protective Service, law enforcement or others as needed.

The NF is responsible for collecting the member liability amount each month and should represent the liability in **box 39** on each claim. The payment remitted by Amerigroup will be reduced by the member liability amount.

The NF should also complete and send an MS-2126 to the case worker so the level of care is updated appropriately in the Kansas Automated Eligibility and Child Support Enforcement System.

For circumstances in which the member or responsible party fails to remit payment of the member's liability to the NF, Amerigroup Service Coordinators will assist the facility in convening a discussion with the member and/or responsible party and/or state staff, Adult Protective Service, law enforcement or others as needed. The facility administrator or manager should contact the Amerigroup service coordinator with details regarding the lack of payment of member liability. Details should include:

- The date the last payment was made
- Discussions held with the member/family to date
- Correspondence with the member/family to date
- History of late and/or missed payments, if applicable
- Any knowledge of family dynamics, concerns regarding the responsible party, or other considerations

Upon approval of NF eligibility, the state's eligibility office will issue a notice of action that will identify the patient liability for the first month of eligibility and for the subsequent months.

The provider should then collect the patient liability consistent with the notice of action.

The following situations and responses are provided to assist you with addressing member liability collection.

Example 1:

The member is approved for institutional NF eligibility as of the 15<sup>th</sup> of the month.

- State issues notice of action for the month for the amount of \$500 and for the following month forward of \$1,000 per month.
- The facility per diem is \$150:  $150 \times 15 = \$2,250$ .
- The facility collects the \$500 patient liability, represents the amount on the claim form in box 39 and bills the MCO for \$2,250.
- The MCO will reduce the \$2,250 by \$500 and remit \$1,750.
- If a member is discharged to home or expires mid-month, the provider may retain the patient liability up to the total charges incurred for the month before discharge.

Example 2:

The member is approved for institutional nursing facility eligibility as of the first of the month and is discharged during the month.

- Patient liability is \$1,000.
- Per diem is \$150.
- Member is discharged on day 7:  $7 \times \$150 = \$1,050$ .
  - Provider retains all of the patient liability and represents the amount on the claim to the MCO.
- Member is discharged on day 3:  $3 \times \$150 = \$450$ .
  - Provider refunds \$550 to the member/family or estate.
  - Provider submits a claim to MCO for three days representing the patient liability collected and MCO reduces the payment by the patient liability and issues a \$0 claim payment.

If a member transfers facilities mid-month:

- Eligibility office is contacted regarding impending transfer and expected dates.
- Eligibility office issues a notice of action to the discharging facility for the patient liability it is to collect for the discharge month.

- Eligibility office issues a notice of action to the receiving facility as to the patient liability it is to collect in the first month and for subsequent months.

### **Amerigroup Approach to NF Member Liability**

Amerigroup recognizes the unique challenges faced by Nursing Facility (NF) providers. For Kansas, Amerigroup will develop intensive training for nursing facilities to address a member/family that is noncompliant in paying the member liability; including facilitating a transfer if the issue cannot be resolved.

The paragraphs below outline our plan for working with the NF and the member/family to resolve such issues.

1. The NF administrator or office manager contacts our Service Coordinator with details regarding the lack of payment of the member liability including:
  - The date the last payment was made
  - Discussions held with the member/family to date
  - Correspondence between the member/family to date
  - History of late and/or missed payments, if applicable
  - Any knowledge of family dynamics, concerns regarding the responsible party or other considerations
2. An Amerigroup Service Coordinator and the Nursing Home Social Worker, if applicable, discuss the issue with the member, determine the barrier to payment and elicit cooperation:
  - The Amerigroup Service Coordinator guides the discussion using pre-determined talking points, including review of the obligation, potential impact to ongoing eligibility, and potential threat to continued residence at the current NF
  - Amerigroup talking points will be provided to the state for review and approval as may be applicable
  - The Amerigroup Service Coordinator screens for any potential misappropriation of funds by family or representative payee
3. The Amerigroup Service Coordinator will discuss the issue with the identified responsible party if the member is unable to engage in a discussion regarding payment of the member liability due to cognitive impairment or other disabilities.
4. The Amerigroup Service Coordinator or NF Social Worker will take action if concerns related to misappropriation of funds are raised or suspected, and may:
  - Refer the member to Adult Protective Services and/or law enforcement
  - Submit request to the Social Security Administration to change the representative payee status to the person of the member's choosing or the NF
  - Engage additional family members
  - Engage the Guardianship Program to establish a conservator or guardian
5. The Amerigroup Service Coordinator will request copies of the cancelled check or other bank document and/or request copy of receipt issued by the NF for payment of liability if the member or responsible party asserts that the required liability has been paid. The Service Coordinator will present evidence of payment to the NF business office and request confirmation that the issue is resolved. The Amerigroup Service Coordinator will also engage the assigned Amerigroup Provider Relations Representative to work with the NF to improve its processes.
6. Amerigroup will send correspondence that outlines the obligation to pay the member liability, potential impact to ongoing eligibility, and potential threat to continued residence at the current NF if the responsible party is unresponsive and/or living out of the area.

- The correspondence will be submitted to the state for review and approval as required
  - The correspondence will provide the responsible party with an opportunity to dispute the allegation and provide evidence of payment
7. Amerigroup will take the following actions in conjunction with the NF Social Worker if member liability remains unsatisfied after the first rounds of discussion or correspondence:
- Convene a formal meeting with the NF leadership, member and/or responsible party, Long-term Support Services Ombudsman, Adult Protective Services representative, other representative of the state as applicable, and other parties key to the discussion
  - Review the patient liability obligation and potential consequences of continued nonpayment
  - Attempt to resolve the payment gap with a mutually agreed-upon plan
  - Explain options if the member or responsible party wishes to pursue transfer to another facility or discharge to the community

Amerigroup, together with the NF, will engage in any of the following, as may be applicable if the member liability continues to go unsatisfied:

- Update and escalate intervention by Adult Protective Services or law enforcement
- Refer to State Medicaid Fraud Control Unit or other eligibility of fraud management staff that the state may designate
- Escalate engagement to facilitate a change to representative payee, Power of Attorney, or Guardian
- Escalate appointment of a volunteer guardian or conservator
- Initiate discharge planning

### **Service Coordination**

The Amerigroup Service Coordination model promotes cross-functional collaboration in the development of member service strategies. Members identified as waiver members, high risk and/or with complex needs are enrolled into the service coordination program and are provided individualized services to support their behavioral, social, environmental, and functional and health needs. Service Coordinators accomplish this by screening, assessing, and developing targeted and tailored member interventions while working collaboratively with the member, practitioner, caregiver and natural supports.

Since many Amerigroup members have complex needs that require services from multiple providers and systems, gaps may occur in the delivery system serving these members. These gaps can create barriers to members receiving optimal care. Our service coordination model helps reduce these barriers by identifying the unmet needs of members and assisting them to find solutions to those needs. This may involve coordination of care, assisting members in accessing community-based resources, providing disease-specific education, or any of a broad range of interventions designed to improve the quality of life and functionality of members and to make efficient use of available health care and community-based resources.

The scope of the Service Coordination Model includes but is not limited to:

- Annual assessments of characteristic and needs of member populations and relevant sub-populations.
- Initial and ongoing assessment.
- Problem-based, comprehensive service planning, to include measurable prioritized goals and interventions tailored to the complexity level of the member as determined by the initial and ongoing assessments.
- Coordination of care with PCPs and specialty providers.
- Providing a service coordination approach that is “member-centric” and provide support, access and education along the continuum of care.

- Establishing a plan that is personalized to meet a member's specific needs and identifies: prioritized goals, time frames for reevaluation, resources to be utilized including the appropriate level of care, planning for continuity of care and family participation.
- Obtaining member/family/caregiver input and level of participation in the creation of a service plan that includes the development of self-management strategies to increase the likelihood of improved health outcomes that may result in improved quality of life.

### **Discharge to the Community**

Amerigroup assists with discharge planning, either to the community or through a transfer to another facility, if the member or responsible party so requests.

If the member or responsible party requests a discharge to the community, the Service Coordinator will:

- Collaborate with the NF Social Worker to convene a planning conference with the NF staff to identify all potential needs in the community
- Facilitate a home visit to the residence where the member intends to move to assess environment, durable medical equipment (DME) and other needs upon discharge
- Convene a discharge planning meeting with the member and family, using the data compiled through discussion with the NF staff as well as home visit, to identify member preferences and goals
- Involve and collaborate with community originations such as Community Developmental Disability Organizations (CDDOs), Centers for Independent Living (CILs) or Area Agencies on Aging (AAAs) in this process to assist members as they transition to the community
- Finalize and initiate execution of the transition plan

Although our member-centric approach is driven by the member, the transition implementation is a joint effort between the NF Social Worker and the Amerigroup Service Coordinator.

### **Notification Requirements**

We request network hospitals to notify us within one business day if the level of care for a patient changes. ***This is not the same as requesting a precertification.*** Call our Provider Services team 24 hours a day, 7 days a week at 1-800-454-3730 or send a fax to 1-800-964-3627. Our medical management staff will verify eligibility and determine coverage. A concurrent review nurse will review and authorize the coverage of emergent admissions.

Documentation must be complete. We will notify the hospital to submit whatever additional documentation is necessary. If our medical director denies coverage, the attending provider will have an opportunity to discuss the case with him or her. The attending emergency room physician or provider who actually treats the member is responsible until, and to determine when, the member is stabilized.

We will mail a Notice of Action to the hospital, the member's PCP and the member, and include the member's appeal and fair hearing rights and process if coverage is denied.

Please copy Amerigroup on all incident reporting to the state of Kansas. You should do so by writing to or sending an email to:

Amerigroup Kansas, Inc.  
9225 Indian Creek Parkway, Building 32  
Overland Park, KS 66210

## Claims Submission

We offer providers several options to submit claims to Amerigroup. For your convenience, you can continue sending your Kansas Medicaid claims to the state electronically. KDHE will submit your claim information to each MCO through daily 837 batch files.

Paper claims should be submitted directly to Amerigroup:

Amerigroup Kansas, Inc.  
P.O. Box 61010  
Virginia Beach, VA 23466

You can also submit claims directly on the Amerigroup website. You can submit claims electronically by using a clearinghouse via Electronic Data Interchange (EDI). By using the free electronic tools we offer on our website, you may be able to reduce claims and payment processing expenses.

Do not alter or change any billing information (e.g., using white out, crossing out, writing over mistakes, etc.); altered claims will be returned to the provider with an explanation of the reason for the return.

Reimbursement to Nursing Facilities is based on a per diem methodology according to applicable Kansas Medicaid NF rates in effect on the date of service. The per diem rates are inclusive of all services rendered in the NF.

### Requirements:

- Billing of NF services should be on a UB-04 claim form and denote the rev codes for routine services.
- Reserve Days (representing a leave of absence) should be billed with the applicable Revenue (REV) code based on the Attachment A of your provider agreement. For example:
  - REV 0180 – General Leave of Absence; Inpatient/psychiatric hospital stay
  - REV 0183 – Therapeutic leave of absence; home therapeutic reserve days
  - REV 0185 – Nursing home leave of absence; hospital reserve days
  - REV 0189 – Other leave of absence; noncovered days. No reimbursement for these days
  - Reimbursement for Reserve Days is calculated based on 67 percent of the all-inclusive per diem rate by facility (with the exception of REV 0189)
- Hospice: For members selecting hospice services, the MCO will pay the hospice for the room and board charges, and the hospice will pay the NF in accordance with CMS methodology and at the current applicable Medicaid rate.
- Member Liability (cost share) should be reported on the CMS-1450/UB-04 claim form, Box 39. Your claim may be rejected if Box 39 is not populated. Even if multiple claims are submitted monthly and the Member Liability is met with the first claim, subsequent claims should indicate \$0 liability.
- Retroactive adjustments: Amerigroup understands the unique requirements of nursing facilities to accept residents as Medicaid pending. As soon as the facility receives notice from the state of the Medicaid approval, the facility should verify eligibility on the Amerigroup website.
- Crossover Claims Procedures: In most cases, when a resident has met the criteria for a Medicare qualified stay in a certified Medicare bed, the Medicare cost share will be relayed to Amerigroup via a crossover file provided to Amerigroup. Amerigroup will then process and adjudicate the crossover claim. No further action should be necessary by the provider.
- Corrected Claims Procedures: A corrected claim Code XX7, or a replacement claim Code XX8, may be submitted within 365 calendar days of the original claim's Explanation of Payment (EOP) date. When submitting a corrected claim, ensure that the applicable claim code is indicated on the claim form. Also ensure that corrected claims contain all applicable dates of service and/or Revenue Codes for processing.

- The following G codes will be covered to differentiate RN and LPN Skilled Nursing Visits in the Home Health and Hospice settings. Providers will bill the following codes for the Acute Care Home Health Service Plan:
  - Service provided by an RN will be coded as G0299 (Direct skilled nursing services of a registered nurse (RN) in the home health or hospice setting); and
  - Service provided by an LPN will be coded as G0300 (Direct skilled nursing of a licensed practical nurse (LPN) in the home health or hospice setting).
  - Codes G0299 and G0300 will be billed for the first 15 minutes of skilled nursing visits. Providers will continue to use T1002 (RN) and T1003 (LPN) subsequent 15 minute increments of a skilled nursing visit. A combination of one G code and up to three T codes may be billed per visit. The Acute Care Home Health Service Plan limitations still apply.

### Claims Processing Approach

In accordance with directives and further clarifications received by KDHE, Amerigroup will delegate collection of patient liability to the NF and will pay the facility/provider net of the applicable patient liability amount. KDHE retains sole responsibility for determining the member's responsibility for patient liability amounts. This information is collected by Amerigroup off the 834-eligibility file received from KDHE.

To ensure Amerigroup Claims Analyst process patient liability correctly, a claim extension screen will be used. This claim screen uses the member liability amount provided by KDHE, which includes the amount and applicable date span and automatically applies the appropriate amount based on the dates of service on the claim and amounts applied to any previous claims.

### Medical and Nonmedical Absence

Members are allowed up to ten days per confinement for reservation of a bed when a NF, NF/MH or ICF/IDD beneficiary leaves a facility and is admitted to an acute care facility when conditions under the reserve day regulations are met. To ensure accurate payment, the NF, NF/MH or ICF/IDD must bill hospital leave days consecutively, beginning with the date of admission.

Members are allowed up to 21 days per admission for reservation of a bed when an NF/MH resident leaves a facility and is admitted to one of the state mental hospitals, a private psychiatric hospital, Prairie View Mental Health Center, or a psychiatric ward in an acute care hospital. To ensure accurate payment, the NF/MH must bill psychiatric leave days consecutively, beginning with the date of admission.

If a beneficiary is not admitted to a hospital but goes to a hospital for observation purposes only, it is considered an approved NF day and **not** a hospital or therapeutic reserve day.

In the event of a **nonmedical** absence from a NF, the facility must report the absence to the local Kansas Department for Children and Families office. These offices do not require MS-2126 forms. A maximum of 18 home-leave days for NFs and 21 days for NF/MHs are allowed per calendar year. Additional days require precertification. Refer to Section 4300 of the KMAP *General Special Requirements Manual* for requirements. The number of nonmedical reserve days is restricted to 21 days per year for ICF/IDD residents.

Providers will not be reimbursed for days a bed is held for a resident beyond the limits set forth above and will not reimburse for medical absences without precertification on the MS-2126 form.

## **APPENDIX D – PROCEDURES FOR PROVIDERS OF WAIVER SERVICES AND OTHER LONG-TERM SERVICES AND SUPPORTS**

### **Member Eligibility for Waivers**

Program eligibility will be determined by the state. This includes financial eligibility and clinical level of care eligibility for the waiver programs.

### **Money Follows the Person**

The Money Follows the Person (MFP) demonstration program not only allows residents to receive Home- and Community-Based Services (HCBS) in the community but also enhanced services that allow for payment of utility deposits and reasonable expenses to re-establish a residence in lieu of continued institutional care. Beneficiaries can receive up to 365 days of MFP services before they transition to one of the several 1915(c) HCBS waivers. The 365 days do not have to be continuous if the member has a brief return to the facility – those days do not count toward the 365 days. Brief stays may include nursing facilities, ICF/IDDs or I/DD individuals in PRTFs who are 18 years of age or older. The individual must have been determined Medicaid eligible for 1 day. Additional information about the program can be found on the Kansas Department of Aging and Disability Services website at [www.kdads.ks.gov/SeniorServices/MFP/MFP.html](http://www.kdads.ks.gov/SeniorServices/MFP/MFP.html).

MPF funding is available to members who meet the functional criteria for one of the following HCBS waivers:

- Frail Elderly
- Physically Disabled
- Traumatic Brain Injured
- Intellectual/Developmental Disabled

### **To be eligible for this program, a member must meet the following criteria:**

- Be a current resident of a nursing facility (NF) or intermediate care facility for people with intellectual or developmental disabilities (ICF/IDD) with a 90-day continuous stay (the 90 days **cannot** include Medicare skilled rehabilitation days).
- Be Medicaid-eligible 30 days prior to receiving MFP services.
- Meet the functional eligibility for waived services.
- Have an interest in transitioning back into the community.

All MFP services, with the exception of targeted case management (TCM), oral health services, and community bridge building, require prior authorization (PA) through the plan of care (POC) process.

Oral health services are available to adults 21 years of age and older who are enrolled in the MFP program. Refer to Exhibit D in the *Dental Provider Manual* or the Scion Dental Provider Manual for services available for HCBS I/DD, TBI, and PD adult beneficiaries.

### **Some Services Offered Under the MFP Demonstration**

In addition to the above services, the MFP demonstration has additional services and funding available to address barriers to successful transition of individuals to community based settings rather than institutional settings (not a complete list):

- Transition services
- Transition Coordination Service
- Therapeutic Support (I/DD & TBI only)
- Community Bridge Building
- Community Transitions Opportunities Counseling



- Assistive Services – These are covered under the HCBS waivers, but under MFP the money spent does not count against HCBS lifetime limits

## **PROCEDURES FOR INTERMEDIATE CARE FACILITY FOR PEOPLE WITH INTELLECTUAL OR DEVELOPMENTAL DISABILITIES (ICFs/IDD)**

For the convenience of ICF/IDD providers, we consolidated some very specific information related to the unique services and issues faced by the industry. However, all other sections of our provider manual not described here are also applicable, such as credentialing, recredentialing, quality programs, etc. and are the responsibility of the ICF/IDD provider, as applicable, based on the scope of services as determined by the provider's licensure.

### **Member Benefit Overview**

- Amerigroup members are entitled room, board, and all per diem services and supplies required for a member in an ICF/IDD.
- Determination of need for long-term placements is determined through the state and Community Developmental Disability Organizations based on the clinical level of care process:
- Once an individual is approved for clinical and financial eligibility, they will be enrolled in a participating KanCare managed care organization as an institutional ICF/IDD member.
- The provider will need to obtain precertification for these services retroactively to the date of the approval.
- Members are entitled to medical and nonmedical leaves of absence (reserve days).
- Members are allowed up to 10 days per confinement for reservation of a bed if member is admitted to an acute care facility.
- If a member is not admitted to a hospital but is there for observation purposes only, it is considered an approved ICF/IDD day and not a hospital or therapeutic reserve day.
- Members are allowed a non-medical leave of absence from an ICF/IDD with a maximum of 21 days per calendar year. Additional days may be available with prior authorization.

### **Member Eligibility**

- Reimbursement is contingent upon proof of member eligibility.
- To check eligibility, please use the Amerigroup eligibility lookup tool to get the most up to date member information. Log in to our provider self-service site, select **Eligibility & Panel Listing** in the *Tools* menu and select **Eligibility**.
- You can also call our Provider Services team to verify member eligibility.

A list of services requiring precertification and notification can be found in your provider manual, as well as on our provider website. Our provider website also houses evidence-based criteria we use to complete precertification and concurrent reviews.

- Submit precertification requests with all supporting documentation immediately upon identifying an ICF/IDD admission or at least 72 hours prior to the scheduled admission.
- For members that enter the facility as "Medicaid Pending" please request precertification as soon as the state approves the Medicaid eligibility and the member's eligibility is reflected on the Amerigroup website.
- The precertification request can be submitted by:
  - Submission on our website
  - Fax the request to 1-800-964-3627
  - Calling Provider Services at 1-800-454-3730
- Providers can obtain the status of a precertification request by:
  - Visiting our provider website
  - Calling Provider Services at 1-800-454-3730

## **Service Coordination**

Our service coordination model promotes cross-functional collaboration in the development of member service strategies. Members identified as waiver members, high risk and/or with complex needs are enrolled into the service coordination program and are provided individualized services to support their behavioral, social, environmental, and functional and health needs. Service Coordinators accomplish this by screening, assessing and developing targeted and tailored member interventions while working collaboratively with the member, practitioner, caregiver and natural supports.

Since many Amerigroup members have complex needs that require services from multiple providers and systems, gaps may occur in the delivery system serving these members. These gaps can create barriers to members receiving optimal care. Our service coordination model helps reduce these barriers by identifying the unmet needs of members and assisting them to find solutions to those needs. This may involve coordination of care, assisting members in accessing community-based resources, providing disease-specific education, or any of a broad range of interventions designed to improve the quality of life and functionality of members and to make efficient use of available health care and community-based resources.

The scope of the Service Coordination Model includes but is not limited to:

- Annual assessments of characteristic and needs of member populations and relevant sub-populations
- Initial and ongoing assessment
- Problem-based, comprehensive service planning, to include measurable prioritized goals and interventions tailored to the complexity level of the member as determined by the initial and ongoing assessments
- Coordination of care with PCPs and specialty providers
- A service coordination approach that is “member-centric” and provide support, access and education along the continuum of care
- A plan that is personalized to meet a member’s specific needs and identifies:
  - Prioritized goals
  - Time frames for re-evaluation
  - Resources to be utilized including the appropriate level of care
  - Planning for continuity of care and family participation
- Obtaining member/family/caregiver input and level of participation in the creation of a service plan which includes the development of self-management strategies to increase the likelihood of improved health and outcomes.

## **Discharge to the Community**

Amerigroup assists with discharge planning, either to the community or through a transfer to another facility, if the member or responsible party so requests.

If the member or responsible party requests a discharge to the community, the Service Coordinator will:

- Collaborate with the Social Worker to convene a planning conference with the ICF/IDD staff to identify all potential needs in the community
- Facilitate a home visit to the residence where the member intends to move to assess environment, durable medical equipment (DME) and other needs upon discharge
- Convene a discharge planning meeting with the member and family, using the data compiled through discussion with the ICF/IDD staff as well as home visit, to identify member preferences and goals
- Involve and collaborate with community originations such as Community Developmental Disability Organizations (CDDOs), Centers for Independent Living (CILs) or Area Agencies on Aging (AAAs) in this process to assist members as they transition to the community
- Finalize and initiate execution of the transition plan

Although our member-centric approach is driven by the member, the transition implementation is a joint effort between the ICF/IDD and the Amerigroup Service Coordinator.

### **Claims Submission**

We offer providers several options to submit claims to Amerigroup. For your convenience, you can continue sending your Kansas Medicaid claims to the state electronically. KDHE will submit your claim information to each MCO through daily 837 batch files.

Paper claims must be submitted direct to Amerigroup:

Amerigroup Kansas, Inc.  
P.O. Box 61010  
Virginia Beach, VA 23466

You can submit claims electronically by using a clearinghouse via Electronic Data Interchange (EDI). By using the free electronic tools we offer on our website, you may be able to reduce claims and payment processing expenses.

Do not alter or change any billing information (e.g., using white out, crossing out, writing over mistakes, etc.); altered claims will be returned to the provider with an explanation of the reason for the return.

Reimbursement to ICF/IDDs is based on a per diem methodology according to applicable Kansas Medicaid ICF/IDD rates in effect on the date of service. The per diem rates are inclusive of all services rendered in the ICF/IDD.

#### **Requirements:**

- Billing of ICF/IDD services should be on a UB-04 claim form and denote the rev codes for routine services.
- Reserve Days (representing a leave of absence) should be billed with the applicable Revenue (REV) code based on the Attachment A of your provider agreement. For example:
  - REV 0180 – General Leave of Absence; Inpatient/psychiatric hospital stay
  - REV 0183 – Therapeutic leave of absence; home therapeutic reserve days
  - REV 0185 – ICF/IDD leave of absence; hospital reserve days
  - REV 0189 – Other leave of absence; noncovered days. No reimbursement for these days
  - Reimbursement for Reserve Days is calculated based on 67 percent of the all-inclusive per diem rate by facility (with the exception of REV 0189)
- Member Liability (cost share) should be reported on the CMS-1450/UB-04 claim form, Box 39. Your claim may be rejected if Box 39 is not populated. Even if multiple claims are submitted monthly and the Member Liability is met with the first claim, subsequent claims should indicate \$0 liability.
- Retroactive adjustments: Amerigroup understands the unique requirements of ICF/IDD facilities to accept residents as Medicaid pending. As soon as the facility receives notice from the state of the Medicaid approval, the facility should verify eligibility on the Amerigroup website and then request an authorization back to the date of eligibility as established by the state. Please note that it may take the state 24 to 48 hours to transmit an updated eligibility to the Amerigroup.
- Corrected Claims Procedures: A corrected claim Code XX7, or a replacement claim Code XX8, may be submitted within 365 calendar days of the original claim's Explanation of Payment (EOP) date. When submitting a corrected claim, ensure that the applicable claim code is indicated on the claim form. Also ensure that corrected claims contain all applicable dates of service and/or Revenue Codes of processing.

### **Claims Processing Approach**

In accordance with directives and further clarifications received by KDHE, Amerigroup will delegate collection of patient liability to the NF and will pay the facility/provider net of the applicable patient liability amount. KDHE retains sole responsibility for determining the member's responsibility for patient liability amounts. This information is collected by Amerigroup off the 834 eligibility file received from KDHE. To ensure Amerigroup Claims Analyst process patient liability correctly, a claim extension screen is used. This claim screen uses the member liability amount provided by KDHE, which includes the amount and applicable date span and automatically applies the appropriate amount based on the dates of service on the claim and amounts applied to any previous claims.

### **Inspection of Care Reviews**

Inspection of Care (IOC) reviews are required for ICF/IDDs and institutions for mental disease (psychiatric state hospitals). This process is performed by KDADS.

### **Physical Disability Waiver**

The Physical Disability (PD) waiver program is designed for Medicaid-eligible beneficiaries from a minimum of 16 years to under 65 years of age who are determined physically disabled by Social Security standards, excluding beneficiaries with a diagnosis of Serious and Persistently Mentally Ill (SPMI), Serious Emotionally Disturbed (SED) or Developmentally Disabled (DD).

Services offered under the PD Waiver include:

- Assistive Services
- Financial Management Services
- Home-Delivered Meals
- Medication Reminder Services
- Personal Emergency Response System and Installation
- Personal Care Services Agency-Directed
- Personal Care Services Self- Directed
- Enhanced Care Services (ECS) Support

### **Traumatic Brain Injury Waiver**

The Traumatic Brain Injury (TBI) waiver is designed to meet the needs of beneficiaries who have sustained a traumatically acquired external non-degenerative, structural brain injury resulting in residual deficits and disability. The TBI waiver is designed to prevent institutionalization. The variety of services listed below are designed to provide the least restrictive means for maintaining the overall physical and mental condition of those beneficiaries with the desire to live outside of an institution.

Services offered under the TBI waiver include:

- Assistive Services
- Financial Management Services
- Home-Delivered Meals
- Medication Reminder Services
- Personal Emergency Response System and Installation
- Personal Care Services/Agency-Directed
- Personal Care Services/Self-Directed
- Rehabilitation therapies: Behavior Therapy, Cognitive Rehabilitation, Physical Therapy, Speech-Language Therapy and Occupational Therapy
- Enhanced Care Services (ECS) Support

- Transitional Living Skills (Not mandatory)

### **Frail Elderly Waiver**

The Frail Elderly (HCBS FE) waiver program is designed to meet the needs of individuals 65 years of age and older who would be institutionalized without these services. The variety of services are designed to provide the most integrated means for maintaining the overall physical and mental condition with the desire to live outside of an institution.

Services offered under the Frail Elderly waiver include:

- Adult Day Care
- Assistive Technology
- Personal Care Services (PCS)
- Comprehensive Support
- Financial Management Services
- Home Telehealth
- Medication Reminder
- Nursing Evaluation Visit
- Oral health services
- Personal Emergency Response
- Enhanced Care Services (ECS) Support
- Wellness Monitoring

### **Children's Technology Assisted Wavier**

The Technology Assisted (TA) waiver program is designed to meet the needs of individuals under 22 years of age who are chronically ill, technology-dependent and medically fragile. These individuals have an illness or disability that requires the level of care provided in a hospital setting. In the absence of home care services, they would require admission and prolonged stay in a hospital or medical institution. Additionally, the individual requires both a medical device to compensate for the loss of vital body function and substantial, ongoing care to avert death or further disability. In order to be eligible for services, the individual must be Medicaid-eligible and meet the level of care eligibility criteria.

Services offered under the TA Waiver include:

- Health Maintenance Monitoring
- Home Modification
- Financial Management Services (FMS)
- Intermittent Intensive Medical Care
- Long-term Community Personal Care Services (PCS)
  - Medical Service Technician (MST)/Agency Directed
  - Personal Care Services (PCS)/Self-Directed
- Medical Respite
- Specialized Medical Care
  - Licensed practical nurse (LPN)
  - Registered nurse (RN)

### **Intellectual and/or Developmental Disabilities Waiver**

The Intellectual and/or Developmental Disabilities (I/DD) Waiver program is designed to meet the needs of individuals ages five or older who would be institutionalized without these services. The variety of services

described below are designed to provide the least restrictive means for maintaining the overall physical and mental condition of those beneficiaries with the desire to live outside of an institution.

Services offered under the HCBS I/DD waiver include:

- Assistive Services
- Day Supports
- Financial Management Services
- Medical Alert-rental
- Overnight Respite
- Personal Care Services (PCS)
- Residential Supports
- Enhanced Care Services (ECS) Support
- Specialized Medical Care
- Supported Employment
- Supportive Home Care
- Wellness Monitoring

### **Critical Incident Reporting and Management**

We have a critical incident reporting and management system for incidents that occur in a home- and community-based long-term care services and supports delivery setting.

We will identify and track critical incidents and shall review and analyze critical incidents to identify and address potential and actual quality of care and/or health and safety issues. We will regularly:

- Review the number and types of incidents (including, for example, the number and type of incidents across settings, providers and provider types)
- Review the findings from investigations (including findings from APS and CPS if available)
- Identify trends and patterns
- Identify opportunities for improvement
- Develop and implement strategies to reduce the occurrence of incidents and improve the quality of HCBS

Critical incidents include the following incidents when they occur in a Waiver setting:

- Unexpected death
- Suspected physical or mental abuse
- Theft or financial exploitation
- Severe injury sustained
- Medication error
- Sexual abuse and/or suspected sexual abuse
- Abuse and neglect and/or suspected abuse and neglect

Providers must report critical incidents to Amerigroup in accordance with applicable requirements. The maximum time frame for reporting an incident to Amerigroup is 24 hours. The initial report of an incident within 24 hours may be submitted verbally, in which case the person/agency/entity making the initial report will submit a follow-up written report within 48 hours. A report must also be filed with KDADS through their Adverse Incident Reporting (AIR) system. Instructions can be found at [www.aging.ks.gov/Manuals/AIR/AIR\\_Instructions\\_Provider.pdf](http://www.aging.ks.gov/Manuals/AIR/AIR_Instructions_Provider.pdf).

Suspected abuse, neglect and exploitation of members who are adults must be immediately reported. Suspected brutality, abuse or neglect of members who are children must also be immediately reported.

Providers must immediately (i.e., within 24 hours) take steps to prevent further harm to any and all members and respond to any emergency needs of members.

Waiver providers with a critical incident conduct an internal critical incident investigation and must submit a report on the investigation. The time frame for submitting the report on the investigation:

- Must be as soon as possible
- May be based on the severity of the incident
- Will be no more than 30 days after the date of the incident except under extenuating circumstances

Amerigroup will review the provider's report and follow-up with the provider as necessary to ensure that an appropriate investigation was conducted and corrective actions were implemented within applicable time frames.

Providers must cooperate with any investigation conducted by Amerigroup or outside agencies (e.g., KanCare, Adult Protective Services, Child Protective Services and law enforcement).

We will:

- Review all of the Fiscal Employer Agent's (FEA) reports regarding investigations of critical incidents and follow-up with the FEA as necessary to ensure that an appropriate investigation was conducted and corrective actions were implemented within applicable time frames
- Provide appropriate training and take corrective action as needed to ensure staff, contract HCBS providers, the FEA and workers comply with critical incident requirements
- Conduct oversight, including oversight of staff, contract HCBS providers and the FEA to ensure the Amerigroup policies and procedures are being followed and necessary follow-up is being conducted in a timely manner

## Elder Abuse

Older adults and those adults with disabilities want to live independently. They need to be safe and as independent as possible. Many cannot depend upon or trust those nearest to them. Those they love the most may abuse them.

Only one in 23 cases is reported. It is not only your moral and ethical obligation to report elder abuse but also your legal obligation.

The types of adult abuse include:

- **Neglect** occurs when the basic needs of a dependent adult are not met by a caregiver. Neglect may be unintentional, resulting from the caregiver's lack of ability to provide or arrange for the care or services the adult requires. Neglect also may be due to the intentional failure of the caregiver to meet the adult's needs.
- **Self-neglect** occurs when a dependent adult is unable to care for him/her or to obtain needed care. The impairments result in significant danger to the adult, and in some situations, deterioration can occur to the point that the adult's life may be at risk.
- **Abuse (physical, sexual and emotional)** generally involves more extreme forms of harm to the adult, including the infliction of pain, injury, mental anguish, unreasonable confinement or other cruel treatment.
- **Financial exploitation** occurs when a caregiver improperly uses funds intended for the care or use of the adult. These are funds paid to the adult or to the caregiver by a governmental agency.

In order to report abuse, please contact the Kansas Department of Children and Family Services, Adult Protective Services which serves adults age 18 or older who are abused, neglected or financially exploited and unable to protect themselves due to mental or physical disabilities or advanced age.

## Electronic Visit Verification Systems (EVV)

The Electronic Visit Verification (EVV) system is an automated system that Amerigroup will utilize to monitor member receipt of certain waiver services as directed by the state of Kansas. Each provider required by the state to utilize EVV will be required to do so through KanCare. Providers are to check in to this system at the beginning and check out at the end of each period of service delivery. This will provide the required confirmation that the member has received the authorized HCBS services.

Applicable provider use of the EVV system will entail dialing the system telephonically from the member's home phone number promptly upon arrival to the member's home. This will confirm the identity of the individual provider/staff worker, as well as confirm the arrival at the proper time and location. At the end of the shift or assignment and prior to leaving the member's home, the provider/staff worker will dial the system from the member's home phone, which will log in the departure time. If the member has no phone, the provider will be required to follow an alternate process for checking in and out of the EVV system. The EVV system will alert Amerigroup if a provider staff person or consumer-directed worker fails to log in at the appropriate time in order that steps can be taken to ensure that the member receives the appropriate care at the appropriate time. Use of this system is compulsory by providers of waiver and HCBS services to Amerigroup members.

The EVV will:

- Log the arrival and departure of the individual provider staff person or consumer-directed worker
- Verify that services are being delivered in the correct location (e.g., the member's home) and at the appropriate time.
- Verify the identity of the individual provider staff person or worker providing the service to the member
- Match services provided to a member with services authorized in the plan of care
- Ensure that the provider/worker delivering the service is authorized to deliver such services
- Establish a schedule of services for each member that identifies the time when each service is needed; and the amount, frequency, duration and scope of each service, and to ensure adherence to the established schedule
- Provide immediate (i.e., real time) notification to care coordinators and appropriate provider if a worker does not arrive as scheduled or otherwise deviates from the authorized schedule so that service gaps and the reason the service was not provided as scheduled, are identified and addressed immediately; this includes through the implementation of backup plans as appropriate
- Log the meals that a provider of home-delivered meals has delivered during the day, including the member's name, time delivered and the reason a meal was not delivered (when applicable)
- Submit claims to Amerigroup
  - Consumer directed claims from workers participating in the consumer-directed program are initially submitted to the Fiscal Employer Agent (FEA), and the FEA will provide claims information to Amerigroup.
- Reconcile submitted claims with service authorizations

The EVV will provide contracted Waiver providers with the following billing-related services:

- **Invoices** – Electronic 837i invoices in the format approved by Amerigroup.
- **Billing Maintenance Reviews** –The ability to review and perform maintenance, as necessary, to all billing prior to submission.
- **Billing/Santrax Maintenance Reports** – Reports of billing items and edits made to billing items; this information will also be provided to Amerigroup

Providers who are delivering home-delivered meals are not required to log in at arrival and departure. Instead, providers will be required to log in after meals have been delivered and enter information on all the meals that were delivered that day.



As a hosted solution, all of the server hardware and software needed to run the EVV system are provided through our multiple redundant data centers. Users access the system through a secure website. The following table shows the recommended computer system requirements for users. These requirements guarantee the fastest connectivity and greatest user satisfaction. However, agencies that do not currently meet the recommended requirements will still be able to access the system, provided they have access to the Internet.

Recommended user set up:

- Microsoft Windows XP, Vista
- Internet Explorer version 7.x or 8.x or Firefox 3.5x
- Video card that supports 1024 x 768, 16-Bit
- Pentium D 2 GHz processor or better
- 1 GB of RAM or better (2 GB of RAM for Vista)
- 1 GB free hard-disk space

### **Service Coordination**

The Amerigroup Service Coordination model promotes cross-functional collaboration in the development of member service strategies. Members identified as waiver members, high risk and/or with complex needs are enrolled into the service coordination program and are provided individualized services to support their behavioral, social, environmental, and functional and health needs. Service Coordinators accomplish this by screening, assessing, and developing targeted and tailored member interventions while working collaboratively with the member, practitioner, caregiver and natural supports.

Since many Amerigroup members have complex needs that require services from multiple providers and systems, gaps may occur in the delivery system serving these members. These gaps can create barriers to members receiving optimal care. Our service coordination model helps reduce these barriers by identifying the unmet needs of members and assisting them to find solutions to those needs. This may involve coordination of care, assisting members in accessing community-based resources, providing disease-specific education, or any of a broad range of interventions designed to improve the quality of life and functionality of members and to make efficient use of available health care and community-based resources.

The scope of the Service Coordination Model includes but is not limited to:

- Annual assessment of characteristic and needs of member populations and relevant sub-populations.
- Initial and ongoing assessment.
- Problem-based, comprehensive service planning, to include measurable prioritized goals and interventions tailored to the complexity level of the member as determined by the initial and ongoing assessments.
- Coordination of care with PCP's and specialty providers.
- Providing a service coordination approach that is "member-centric" and provide support, access, and education along the continuum of care.
- Establishing a plan that is personalized to meet a member's specific needs and identifies: prioritized goals, time frames for reevaluation, resources to be utilized including the appropriate level of care, planning for continuity of care, and family participation.
- Obtaining member/family/caregiver input and level of participation in the creation of a service plan that includes the development of self-management strategies to increase the likelihood of improved health outcomes that may result in improved quality of life.

**Claims Payments**

Our processing goal for the KanCare program is to adjudicate all clean claims as quickly as possible. Claims are processed upon arrival and payments are sent to providers five times per week. The turnaround of Amerigroup is typically well below the state standard for clean claims which is:

- Within 30 calendar days of receipt for clean claims submitted electronically and clean claims received by mail
- Within 14 calendar days of receipt for electronically submitted clean claims for nursing facility providers

If a provider has more than one location, payments are made only to the location they indicated as their primary location.

## **APPENDIX E – PROCEDURES FOR FINANCIAL MANAGEMENT SERVICE PROVIDERS**

Members in the Physical Disability, Traumatic Brain Injury, Frail Elderly and Development Disability waivers has a right to choose a Financial Management Services (FMS) provider to assist them to self-direct the care they receive through the waivers.

When a member or member's representative chooses you as an FMS provider, he or she must be fully informed by you of his or her rights and responsibilities to:

- Choose and direct support services and the workers who provide the services
- Perform the roles and responsibilities as employer
- Understand the roles and responsibilities of the FMS provider
- Receive initial and ongoing skills training as requested

Once fully informed, the member or member's representative must negotiate, review and sign an FMS service agreement developed and made available by KDHE and distributed by you, the FMS provider. The FMS service agreement will identify the negotiated role and responsibilities of both the member and the FMS provider. It will specify the responsibilities of each party.

### **The FMS provider has the responsibility to:**

- Comply with the provisions of KSA 39-7,100 (Home and community-based services program) and KSA 65-6201 (Individuals in need of in-home care; definitions); [www.kslegislature.org/li/b2013\\_14/statute](http://www.kslegislature.org/li/b2013_14/statute)
- Execute a Provider Agreement with the appropriate state agency; [www.kdads.ks.gov](http://www.kdads.ks.gov)
- Execute a Medicaid provider agreement with the KDHE Division of Health Care Finance; [www.kdheks.gov](http://www.kdheks.gov)
- Comply with state regulations, KDADS provider agreement requirements, Medicaid provider agreement requirements, policies and procedures to provide services to eligible beneficiaries
- Develop and implement procedures, internal controls and other safeguards that reflect Kansas state law (the guiding principles of self-direction) to ensure the member or member's representative, rather than the FMS provider, has the right to choose, direct and control the services and direct support worker(s) who provide them without excessive restrictions or barriers ; the procedures, internal controls and other safeguards must be written and must include, at a minimum:
  - A mechanism to process the direct support worker's human resource documentation and payroll in a manner that is efficient and supports the member or member's representative's authority to select, recruit, hire, manage, dismiss and train direct support workers
  - Information for the direct support worker that outlines the completion of timekeeping process, wages, benefits, pay days, work hours and the member's self-direct preferences
  - An assurance that the enrollee or enrollee's representative, not the FMS provider, determines the terms and conditions of work (e.g., when and how the services are provided, such as establishing work schedules, determining work conditions; for example, smoking restrictions in the home, conditions for dismissal and tasks to be performed)
  - Internal controls to ensure the member or member's representative is afforded choice and control over workers without excessive restrictions or barriers
  - A process to respond, within a reasonable time frame, to contact from the member or member's representative informing the FMS provider of the decision to dismiss a particular direct support worker
  - A process for the self-directing member or member's representative to pay the direct support worker(s) or for the self-directing member or member's representative to delegate the direct support worker(s) payment by direct deposit, first-class mailing or other means through the FMS provider agency staff

- Ensure the self-directing member or member's representative and the case manager have the name and contact information of the FMS provider agency staff who can address their issues
- Assume responsibilities in providing the following administrative services:
  - Establish and maintain all required records and documentation, to include a file for each self-directing member per KDHE regulations, policies and procedures and in accordance with Medicaid provider requirements; all files must be maintained in a confidential, HIPAA-compliant manner
  - Obtain authorizations to conduct criminal background checks and child abuse and adult registry checks in accordance with applicable waiver requirements
  - Verify citizenship and legal status of potential direct support workers
  - Collect and process all required federal, state and local human resource forms required for employment and the production of payroll
  - Help the self-directing member or member's representative set the correct pay rate for each direct support worker as allowed under the procedures set by KDHE
  - Verify and process time worked by direct support worker(s)
  - Compute, withhold, file and deposit federal, state, and local employment taxes for the direct support worker(s)
  - Compute and pay workers compensation as contractually and statutorily required
  - Approve and pay wages to the direct support worker(s) in compliance with federal and state labor laws
  - Perform all end-of-year federal, state, and local wage and tax filing requirements, as applicable (e.g., IRS forms W-2 and W-3, state income tax forms and reporting)
  - Have policies and procedures in place for reporting fraud and/or abuse, neglect, or exploitation by a direct-support worker to the appropriate authority and informing the member or member's representative that if the direct-support worker continues to work for the member, he or she will no longer be able to serve as the FMS provider agency
- Ensure each self-directing member is:
  - Maintaining control and oversight of his or her direct support worker
  - Aware of the benefits/services available to him or her
  - Aware of his or her requirements and responsibilities to the FMS provider agency
  - Aware of his or her requirements and responsibilities to the direct support workers, including assigned Employment Service Agreement that specifies the responsibilities of the parties in a language/format that is understandable to the worker
- Ensure each direct-support worker hired by the self-directing member is aware of the:
  - Benefits/services available to him or her
  - Employment requirements and job responsibilities of the self-directing member and FMS provider
- Maintain listing of direct-support workers who are available and desire additional employment
- Develop, implement and maintain an internal quality assurance program that monitors for:
  - Self-directed member's satisfaction
  - Direct-support worker's satisfaction
  - Correct submission of direct-support worker's time worked
  - Correct payroll distribution
- Develop, implement and test an adequate backup plan that ensures records are preserved and fiscal functions are replicated in case of a natural disaster or state of emergency
- Maintain evidence of certifications, agreements and affiliations as required by waiver or policy (such as community developmental disability organization [CDDO] affiliation agreements for developmental disabilities services)

